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The perception, management and experience of stigma among people with mental illness in Japan

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**The Perception, Management and Experience of Stigma among People with Mental
Illness in Japan**

Namino Kunitoh

A thesis submitted to King's College London in fulfilment of the requirements for the
degree of Doctor of Philosophy

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I would like to dedicate this thesis to these individuals.

Abstract

The present study aimed to: (1) clarify the time trends in social attitudes to mental illness in Japan, (2) clarify how people with mental illness perceive, manage and experience stigma in Japan, with a sub-focus on changes over time and (3) describe the relationships between the perception, management and experience of stigma in detail. Social attitudes were explored in order to better understand what reasons lie behind the perception, management and experience of stigma among people with mental illness.

The study employed: (1) an analysis of newspaper articles, (2) an analysis of magazine articles and (3) interviews with those with a diagnosis of either schizophrenia or depression. The results of the analysis of the newspaper articles showed that articles regarding mental illness had changed from an emphasis on reporting its dangerousness to reporting of the personal stories of those affected and the relationship with stress between 1987 and 2014. The analysis of magazine articles revealed that many people with mental illness had perceived negative images of mental illness in society, concealed their illness and were discriminated against or faced others' lack of understanding of mental illness. There were few qualitative changes in their perception, management and experience of stigma over time. The results of an analysis of the interview data showed that the perception, management and experience of stigma were part of the process of living with a self that has changed because of mental illness and psychiatric diagnosis. The interview participants' self-perception changed after they had accepted their psychiatric diagnosis, and they perceived, managed and experienced stigma in the process of living with a self that had changed. The findings of the study suggested that the perception, management and experience of stigma could be universal, although there may be different cultural or social reasons behind the perception, management and experience.

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PREFACE

The objectives of the present study are:

- (1) to clarify the time trends in social attitudes towards mental illness¹ in Japan and,
- (2) to clarify how people with mental illness perceive, manage and experience negative stigma² in Japan, with a sub-focus on the changes over time.

Previous literature has made it clear that many people with mental illness have experienced stigma – defined in the present study as ignorance, prejudice and discrimination – and this trend seems universal (Alonso et al., 2008; 2009; Thornicroft et al., 2009). Studies have shown that experiencing stigma is often related to negative consequences. For example, higher levels of stigma are correlated to a lower quality of life (Depla et al., 2005; Świtaj et al., 2009), lower sense of coherence³, empowerment and self-esteem (Lundberg et al., 2009) or lower willingness to disclose one's diagnosis (Lasalvia et al., 2013). Although it is important to explore concrete examples of experienced stigma among those with mental illness, and this can lead to finding possible ways to reduce stigma against mental illness, it is also necessary to include an analysis of the perception and management of stigma in examining the experience of stigma. This is because perception and management can be the background of the experience of stigma. For instance, when people with mental illness are aware that those affected would be regarded and treated in a negative way, they may try to cope with stigma by, for example,

¹ In this study, mental illness refers to, in principal, illnesses classified by codes F00-F99 in the International Classification of Diseases 10, and people with mental illness principally means those who have been diagnosed with the illness by medical professionals. However, dementia, substance-related disorders, intellectual disability and developmental disorders are not included in mental illness in the present study. Dementia and substance-related disorders are omitted because this study excluded people with cognitive impairment and/or substance abuse problems when recruiting interview participants. Moreover, the remaining diagnoses are not included as the Ministry of Health, Labour and Welfare of Japan do not regard them as mental illness according to their criteria.

² I limited stigma to negative stigma and excluded positive stigma, mainly for practical reasons. I did not expect that people with mental illness in Japan would experience positive stigma frequently. This assumption was based on the findings of existing studies in Japan, descriptions of those affected in the media, people's discussion about them, my interviews with people with mental illness and mental health professionals (which had been conducted for another study prior to the present study), and from talks with people with mental illness and with mental professionals whom I personally knew. I therefore felt that it would not be easy to reach people with mental illness who had experienced positive stigma when recruiting participants in Japan.

³ The authors defined sense of coherence as 'the extent to which one has a pervasive, enduring though dynamic, feeling of confidence that one's environment is predictable and that things will work out as well as can reasonably be expected'.

concealing their illness. However, when their illness becomes known to others, they may experience stigma. Although there is a large body of literature concerning the experience of stigma among people with mental illness, particularly in Europe and the US, most of the studies focus on the experience itself, and do not examine it in relation to the perception and management of stigma. A subsidiary aim of the present study is, therefore, to present a detailed description not only of experienced stigma, but also its background, namely the perception and management of stigma; indeed, this will provide a more comprehensive understanding of stigma.

In Japan, as will be seen in Chapter One, mental health care has been hospital-centred, and yet it has been gradually shifting towards early discharge, with legal and policy changes. The Japanese government are aiming to promote community-based care, which will increase the number of people with mental illness living in the community in future. One of the difficulties which people with mental illness may face in their community lives is stigma against their illness, and thus it is important to understand how they perceive, manage and experience stigma in Japan. Furthermore, it is also necessary to understand social attitudes to mental illness when examining the perception, management and experience of stigma among those affected, as these aspects can be affected by stigma possibly resulting from social attitudes towards mental illness. However, little is known about how people with mental illness perceive, manage and experience stigma in Japan. Furthermore, although there is a large body of literature on social attitudes towards mental illness in Japan, there have been no longitudinal studies.

The present study aims to explore the time trends in social attitudes towards mental illness and how people with mental illness perceive, manage and experience stigma in Japan, with a sub-focus on the changes over time. It is hoped that this will facilitate an understanding of the present situation in comparison to the past⁴.

⁴ If this study employed a cross-sectional design and only examined the current social attitudes towards mental illness and how those affected perceive, manage and experience stigma today, the interpretation of the results would mostly depend on comparisons with the findings of studies conducted in other countries. This would be particularly true when interpreting the results of the perception, management and experience of stigma among people with mental illness in Japan, as there have been few studies which have focused on this, and thus it is difficult to compare the results to those of prior Japanese studies. Although it is important to make a comparison between Japan and other countries, it also is important to make a comparison on a domestic level in order to obtain a deeper understanding of social attitudes towards mental illness and the perception, management and experience of stigma among those affected. For instance, levels of stigma in Japan might seem higher than those in other countries when making an international comparison, and yet it may be possible to understand that people with mental illness are less stigmatised today than in the past when comparing stigma in present-day Japan with that of Japan in the past.

The frames ‘Japan as a nation’ and ‘Japanese culture’ are employed by the present study, but are arguable concepts (Morris-Suzuki, 1998). Even when defining ‘Japan’ geographically there are difficulties, as the border has changed several times. For instance, the Ryukyu Kingdom, which had been an independent Kingdom, was annexed to Japan as ‘Okinawa prefecture’ by the Japanese government in 1879. Furthermore, so-called ‘Japanese culture’ is also not as simple and uniform as to be summarised as one category. Even in the same period, each local area has unique manners and customs. ‘Japanese culture’ has also been influenced by foreign culture. As will be seen in the next chapter, Japan was influenced by China, Korea and the Netherlands due to the importation of various goods and academic disciplines until the end of the nineteenth century; Japan has also been influenced by the United States, France, Germany and Britain since then.

The reasons why the present study employs the frames ‘Japan as a nation’ and ‘Japanese culture’ are two-fold. First, the present study aims to clarify the perception, management and experience of stigma among people with mental illness in Japan. These three elements can be affected by mental health-related laws and systems which are unique to Japan as a nation and by culture in Japan. As such, the frames ‘Japan as a nation’ and ‘Japanese culture’ are deemed to be useful in the present study. Second, although it becomes difficult to describe the complexity and diversity of the reality by employing these two frames, they do make it possible to generalise how people with mental illness in Japan perceive, manage and experience stigma to some degree. Furthermore, by generalising the results of the present study using these frames, it becomes possible to compare the findings of the present study with those of existing studies conducted in other countries, many of which employ the same frames.

The contents of the chapters in the present study are as follows:

Chapter One presents the history of mental health care in Japan, including changes in law and policy. It also describes the major characteristics of the current psychiatric provision and provides some statistical pictures about the employment and financial status of people with mental illness. Chapter Two is a review of the literature on social attitudes towards mental illness in Japan. This includes studies using representative samples, those employing convenience samples, and international comparative studies. Chapter Three provides a review of prior literature pertaining to the perception, management and experience of stigma among people with mental illness, mostly from European or American studies.

Chapter Four presents the methods used for the present study. It details the specific methods employed, including qualitative content analysis (used to analyse newspaper articles and magazine articles) and the grounded theory approach (used to analyse interview data). Chapter Five presents findings concerning the changes in social attitudes towards mental illness, analysed through newspaper articles. It shows how social attitudes towards mental illness in general have changed, and also by diagnosis and by newspaper. This chapter also discusses the findings, comparing them with those of prior studies. In Chapter Six, the findings concerning the perception, management and experience of stigma are presented. Concrete examples of these three elements are derived from the analysis of magazine articles, whilst the findings of qualitative interviews provide a detailed picture of how the three elements are related. This chapter also examines how these findings can be interpreted in the context of the changes in social attitudes towards mental illness which are shown in Chapter Five. Chapter Seven discusses the findings as they pertain to the perception, management and experience of stigma among people with mental illness in Japan; indeed, these findings are also compared with those of prior studies and placed in theoretical contexts. The chapter also considers the implications of the study, as well as the limitations and significance of the study.

CHAPTER ONE: MENTAL HEALTH CARE AND MENTAL ILLNESS IN JAPAN

This chapter presents the history of mental health care in Japan, including changes in law and policy. It also describes the major characteristics of the current psychiatric provision and provides some statistical pictures regarding the employment and financial status of people with mental illness.

1-1. Historical background: how were people with mental illness treated in Japan?

As we saw in the Preface, the objectives of the present study are to clarify (1) the time trends in social attitudes towards mental illness in Japan and (2) the perception, management and experience of stigma among people with mental illness in Japan, with a sub-focus on the changes over time. In clarifying these, we need to understand how mental illness has been regarded and how people with mental illness have been treated in Japan historically, so as an effective comparison can be made with the current situation. This section presents a brief history of the treatment of people with mental illness in Japan from the seventh century to date.

1-1-1. From the seventh century to the nineteenth century

In Japan, people had long held the belief that mental illness was caused by possession. *Fusôryakuki* (a series of books about the history of Japan which was completed at the end of the twelfth century) includes a description of possession, whereby Her Majesty the Empress becomes mad after a fox possesses her in 888. Okada (2002, p. 42) notes that this is probably the oldest record of fox possession. The notion of possession was widely employed to explain mental illness until the end of the nineteenth century, when neuro-oriented German psychiatry was introduced.

When people believed that possession was the reason for mental illness, the treatment for said illness was to exorcise the thing which possessed someone so that the person could return to her/his previous self. In the treatment, Buddhist priests performed incantations and prayer (Suzuki, 2011; 2012). Buddhist temples were also an important place for mentally ill people. In the temple, mentally unwell people usually recited a sutra or purified themselves by sitting in the torrents of a waterfall, taking a hot spring bath, or soaking themselves in the sea (hydrotherapy). Indeed, these were regarded as

cures for mental illness. People with mental illness stayed in temples for some time until they recovered. In some temples, it was also common for families to stay together in order to look after their ill members (Hashimoto et al., 2010).

Whilst the treatment mentioned above had been common since the seventh century, another type of treatment emerged in the twelfth century: treatment with Chinese or Japanese herbal medicines. This type of medical treatment, however, had a relationship with Buddhism, as did the incantations, prayer, the reciting of a sutra, and hydrotherapy. Those who offered treatment to mentally ill people with Chinese or Japanese herbal medicines were Buddhist priests who had knowledge of Buddhist medicine, and the loci of treatment was Buddhist temples. One of the temples with a history of treating the mentally ill with these herbal medicines is Jun'inji, which started to offer medical treatment in the fourteenth century. This temple became a psychiatric hospital in 1946 and still serves as one today (Omata, 1998). In this hospital, Chinese or Japanese herbal medicines, or moxa cautery, in addition to psychotropic medicines, are still used in treatment, according to patients' needs (Okada, 2002, p. 48).

During the Edo period (1603-1867), the central government closed the country to foreigners with a few exceptions, including people from the Netherlands, China, Korea and the Ryukyu Kingdom (later Okinawa prefecture, Japan). It was a relatively peaceful period because of the closed-door policy, and Japan enjoyed economic stability as well as the development of commerce and industry. The major characteristics of health care in this period include: the number of people who worked as professional doctors increased and they usually visited their patients' homes because there were few hospitals; some doctors kept a distance from Buddhism and it became common for lay people to keep medicines at home. Doctors treated people using acupuncture and moxibustion or Chinese or Japanese herbal medicines (Itahara and Kuwabara, 2001; Miyamoto, 2006). Two mental surgeries, which were not related to Buddhism, were established in this period. In these surgeries, mentally ill patients were treated by doctors who had learnt Oriental medicine, while Chinese or Japanese herbal medicines were used (Okada, 2002, pp. 46-48). These surgeries later became mental hospitals, yet they had closed their doors by the end of the Second World War (Omata, 1998, pp. 158-166). Whilst medical treatment based on Oriental medicine and Chinese or Japanese herbal medicines became more common among lay people, particularly in urban cities, the custom of staying in temples for the treatment of mental illness was not lost, but coexisted with the medical treatment in the Edo period (Nakamura, O, 2013; Takahashi,

2006).

However, traditional care, including both religious and Oriental treatments, gradually declined from the end of the nineteenth century. Japan witnessed drastic changes between the 1850s and 1910s, after the long-lasting closed period. The central government had continued to refuse any offers from foreign countries to start trade, other than the Netherlands, China, Korea and the Ryukyu Kingdom, but they finally agreed to open two ports to American ships in 1854. The government concluded commerce treaties with several Western countries including the United States, France and Britain in 1858. Thus, Western merchandise started to spread across Japan, and the government aimed to rebuild the nation as an equal competitor to Western countries by introducing Occidental techniques and reinforcing economic and military power.

The change in policy to encourage the introduction of Western techniques also affected medical fields. The prohibition of learning about Western culture and studies, which was established in 1849⁵, was withdrawn in 1858. Whilst medical education was based on Dutch or British medicine until 1869, the government decided to have Japanese medical students learning German medicine in 1870⁶, and asked the German government to send several doctors to Japan in order to educate Japanese students in 1870. The German government agreed, and medical education in Japan shifted to the German style after this time (Fujita, 1995). Hence, Japanese modern medicine was established under the great influence of German medicine. Psychiatry was not an exception either. In 1886, the Department of Psychopathology was established at the University of Tokyo for the first time in Japan. The first professor was Hajime Sakaki, who learnt psychopathology in Germany. Other members of the academic staff had also studied in Germany or Austria. Adopting German neuropsychiatry, Japanese psychiatry came to be oriented towards neurology (Omata, 2000).

During the Meiji period (1868-1912), the government aimed to establish a new

⁵ In the middle of the nineteenth century, the number of physicians who learnt Western medicine increased and it became more common for medical students to learn Western medicine at private schools. However, those who learnt traditional Japanese medicine and taught at national schools objected to giving students Western medical education. Because traditional medicine was under the control of the state at that time, the government needed to protect it. Thus, they prohibited learning about Western culture and studies in 1849, with the aim of protecting classical medicine (Omata, 2000).

⁶ One of the reasons why the Japanese government decided to choose German medicine is that G.H.F. Verbeck, a Dutch-born American and appointed teacher at the University of Tokyo, stated that Germany had the greatest knowledge and practice in medicine. Another reason is that the key people in the government had a sense of affinity with Germany, because Japan and Germany shared the similar characteristic of having an Emperor (Fujita, 1995).

medical system by introducing Western treatment. In their efforts towards this goal, they not only encouraged the introduction of Western medical knowledge and practice, but also prohibited Japanese traditional treatment customs such as herbal medicine or moxa cautery. In 1874, the government excluded a subject on traditional medicine from the examination for an official licence to practice medicine and also excluded the subject from courses at newly established medical schools. However, they allowed existing physicians, most of whom were those trained in traditional medicine, to continue to work as doctors without having taken the examination for the licence (The Medical Law, 1874). As a result, doctors trained in traditional medicine were rapidly replaced by those who had learnt Western medicine. The proportion of the latter among all doctors rose from 25-36%⁷ to 76% between 1875 and 1912 (Home Department, 1877, pp. 39-45; 1914, pp. 65-66). The government also prohibited religious treatment; treatment of illness by people with a religious background, such as Buddhist ascetics, was banned in 1882 and the custom of staying in temples for treatment was also banned in 1900.

For the government, the prohibition of religious treatment (treatment based on Buddhism in particular) was necessary in order to diffuse Western medicine among lay people and thus become more internationally competitive. Whilst Japan introduced Occidental institutions and practices with the intention of rebuilding the nation as an equal competitor to Western countries, it was also necessary to introduce and diffuse Western thoughts behind these institutions and practices in order to diffuse Western institutions and practices in Japan (Barshay, 2004). The government wanted to westernise Japanese people's thoughts as well. Therefore, many things which appeared 'odd' in the eyes of Westerners had to be denied (Narita, 1995). One of these was the belief of possession, and treatment for possession, namely religious (Buddhistic) treatment; indeed, this was banned. On the other hand, prohibition of religious (Buddhistic) treatment was also one of the results of the government's policy for establishing Shinto as the national religion. In 1868, the government adopted this policy for several reasons, including deification of the Emperor; indeed, they also oppressed religion other than Shinto, and particularly Buddhism⁸ (Funaki, 2005).

Although there is relatively little statistical data on the number of people who

⁷ The proportion changes are included, depending upon whether the number of doctors trained both in traditional and Western medicine.

⁸ This policy, however, ended after a few years, mainly because of strong resistance by Buddhists in Japan and criticism from European countries (Toda, 2010).

received religious treatment, it is expected that the changes in laws, in addition to the Westernisation of the medical system, led to a significant decline in this type of treatment. Traditional and religious treatment have become relatively rare nowadays. This, however, does not mean that classic treatment practice has disappeared completely. For instance, and as seen earlier, Chinese or Japanese herbal medicines, or moxa cautery, are still used in medical treatment in some hospitals even nowadays, and a variety of Chinese or Japanese herbal medicines are sold at pharmacies, alongside Western medicines. Furthermore, there are some people who go to a temple in order to purify themselves by sitting in the torrents of a waterfall, although their purposes include not only treatment for illness, but also relaxation or other reasons (Hyôdô, 2012; Kanekawa and Hori, 2006).

Thus, traditional care is still alive to some degree, although the introduction of psychiatry and the diffusion of psychiatric knowledge, along with the decline of classic treatment, had a great influence on changing people's views regarding mental illness and those affected. Satoh (2012) argues that, through the analysis of newspaper articles published between the end of the nineteenth century and turn of the twentieth century, 'madness' was turned into 'mental illness' and the Japanese public must have begun to understand the seriousness of the illness and the significance of Western medical knowledge in this period. Similarly, Kawamura (2006) points out that possession and 'ki-disease'⁹ were re-defined by psychiatrists as disorders of the brain or nerves, and psychiatric labels such as 'brain disease' became common among lay people in the Meiji period (1868-1912). Today, although there are differences in views on mental illness across certain areas¹⁰, deviant thoughts and behaviour are usually interpreted in the psychiatric context. This implies that old notions such as possession have largely been replaced by psychiatric concepts¹¹.

⁹ It was thought that emotions were movable in the body like blood, and sudden and intense emotions could cause ki (invisible life energy)-stagnation, which was regarded as the major cause of mental illness in the Edo period (Tashiro, 1979).

¹⁰ There are some rural areas where people still believe that mental illness can be caused by possession (Higashimura, 2000).

¹¹ According to Hyôdô (2009), mentally ill people were not isolated but were in relationships with others when religious treatment was common, as it was thought that possession occurred when someone had problems with others and this treatment required not only clients but also people around them including their family and neighbours to attend. However, psychopathology destroyed the relationships between the mentally ill and people around them by treating mental illness as something which results from personal problems.

1-1-2. The twentieth century and onwards

As opposed to Western countries, such as England and the United States, there have been no large asylums in Japan. Until the end of the nineteenth century, when Western medical knowledge was introduced, there were also relatively few hospitals.

In 1900, the Confinement Law of the Mentally Ill, which was the first national law regarding mentally ill people, was established. The Law prohibited mentally ill people from receiving care in temples and prescribed that they should be in custody at home or stay in a mental hospital. The Law allowed home custody, as many felt it could serve as an effective treatment for mentally ill people¹² (Utsunomiya, 2010).

Meanwhile, the first mental hospital was established in 1875 in Kyoto, although the number of mental hospitals did not increase rapidly. Therefore, many mentally ill people, and particularly people with a history of violence, had to be in custody at home¹³. Shûzô Kure ('the father of Japanese psychiatry') and his colleagues conducted an on-the-spot investigation into the environment of people who were in custody at home (n = 361), revealing that the most common reason for custody was violence against other family member(s) or breaking furniture. They also observed that many people suffering from mental illness were kept in a locked, dark and narrow room, without any medication or treatment (Kure and Kashida, [1918] 1973). Indeed, Kure states 'we should say that tens of thousands of mentally ill people in our country have the misfortune to have been born in this country as well as the misfortune to have had the illness' (Kure and Kashida, [1918] 1973, p. 138). However, although it must be true that some mentally ill people received cruel treatment in home custody, there were also families which had ill members in custody and did not want to hospitalise them, even if it was free, as the families were worried that their ill members might be treated badly in hospital and they wanted to look after them by themselves¹⁴ (Kodama, 1934). In fact, there were people, including a German psychiatrist and Japanese government officers, who regarded home custody in

¹² During discussion on the Bill, Kunika Katayama, a specialist in forensic medicine, explained that it was possible to calm a mentally ill person down by putting him/her in a narrow room for a while and, therefore, home custody could work as a treatment (Utsunomiya, 2010).

¹³ According to Akakura (2001), the reason why the number of mental hospitals did not increase lies with the overly detailed regulations on the structure of hospitals (for example, the height from the floor to the ceiling or the width of the corridor) issued by the National Police Agency. Since there were not enough hospitals, poor families often had no choice other than to look after their ill members at home instead of hospitalising them. Understandably, mentally ill people in custody in a poor home were usually not well cared for by their families.

¹⁴ These families' reactions might have stemmed from having read certain newspaper articles about how mental hospitals were horrible places. For instance, such articles were published serially in the Yomiuri Newspaper in 1903.

Japan as one of the ideal methods of care which involved patients being looked after by their own families (Hashimoto, 2005). Therefore, it seems unclear whether it was better for people with mental illness to receive care in hospital rather than at home.

Despite this however, psychiatrists continued to insist upon the necessity of establishing mental hospitals, as they believed that it was best for mentally ill people to receive treatment in hospital (Utsunomiya, 2011). As a result, the Mental Hospital Law, which prescribed that the national government should subsidise half of the establishment cost and about 15% of the management cost of public mental hospitals, was passed in 1919. However, the number of public hospitals did not increase rapidly, mainly because of the lack of a government budget (Akakura, 2003). The Mental Hospital Law also prescribed that a private hospital could be regarded as a public hospital when the former fulfilled certain criteria (e.g. the number of beds and staff). The law also made it clear that the government should pay a certain amount of money to the private hospitals, according to the number of the patients¹⁵. Thus, some private hospitals were designated as public hospitals from the 1920s (Omata, 2000).

Psychiatric treatment was provided mainly through private hospitals, since there were many more private hospitals than public hospitals¹⁶. As there were not enough psychiatric beds, custody at home was legally allowed until 1950, when it was prohibited by the Mental Hygiene Law. Home custody, however, was already becoming less common, even before the passing of the Mental Hospital Law, in terms of the proportion of those who were in custody out of the total number of registered psychiatric patients (from approximately 12% in 1905 to 6% in 1940). On the other hand, the rate of hospitalised patients doubled from approximately 6% to 12% over the same period (Suzuki, 2003), thus suggesting that the trend of hospital-centred care in the psychiatric provision had already started even before the rapid increase in the number of private psychiatric hospitals from the 1950s onwards.

As we have seen, mental health care in Japan changed significantly between the end of the nineteenth century and the mid-twentieth century. Behind this change were academic and social changes over the period, in addition to the revision of laws and establishment and improvement of psychiatric institutions. Following the end of the

¹⁵ Akakura (2003) points out that this regulation reflects the concern among doctors running private hospitals that the numbers of their patients might decrease if public hospitals were actually established.

¹⁶ The proportion of private hospitals constituted approximately 80% of all mental hospitals throughout the first half of the twentieth century (Okada, 1985).

nineteenth century, new academic disciplines such as sociology and economics were introduced. Psychiatry was also one of these new disciplines, which were used not only for purely academic purposes but also for practical purposes; the scholars addressed 'social problems' and aimed to resolve them through politics. Psychiatrists claimed that prostitutes, leftists and wanderers were mentally abnormal and threatened social security, and thus psychiatrists established their status as a professional group that provided these 'mentally abnormal' people with treatment (Hyôdô, 2003; Matsumura, 2004), whilst sociologists made an issue of poverty. These scholars in emerging disciplines formed the new middle class. They influenced the government's policies, including those for dealing with 'social problems', and thus contributed to reconstituting the daily practices of Japanese people. The period spanning the end of the nineteenth century to the mid-twentieth century also witnessed various movements by Christians and charity groups, which aimed to resolve problems such as poverty, orphans and unemployment. Furthermore, during this period, the foundation of the welfare system was established and the government introduced the concept of hygiene, including mental hygiene, under the influence of Western medicine (Ambaras, 1998; Hougetsu, 2010; Sheldon, 1997). As shown above, psychiatric care in Japan formed its base under the influence of social and academic changes in addition to legal and institutional changes by the end of the Second World War.

After the Second World War ended, the Mental Hygiene Law 1950 was established. As home custody became illegal because of this new Law and those who were in custody at home had to receive care in hospital, it was necessary to increase the number of psychiatric beds as soon as possible. Furthermore, a field study on mental hygiene conducted by the Ministry of Health and Welfare in 1954 estimated that there were approximately 350,000 mentally ill people needing to be hospitalised, while the number of psychiatric beds stood at around only 40,000 (MoHW, 1959). The shortage of psychiatric beds was supplemented by a rapid increase in the number of private psychiatric hospitals from the middle of the 1950s. As the government subsidised half of the establishment and management costs of private psychiatric hospitals from 1954, the number of private hospitals rose between the 1950s and 1960s, from 185 in 1953, to 874 in 1969¹⁷ (MoHW, 1976). Thus, the major provider of mental health care remained the

¹⁷ The increase in the proportion of national funding for psychiatric involuntary admission in 1961 might also have influenced the growth of the number of private psychiatric beds. With rapid growth in the number of beds and the psychiatric service exception, which is an administrative guidance

private sector. This private-based care provision has not changed to date. In fact, in 2011, the proportion of private psychiatric hospitals still constituted 95% of all psychiatric hospitals¹⁸ (MoHLW, 2012a).

As often pointed out, private psychiatric hospitals also play a public role in Japan; in private hospitals, most patients pay for medical services using their insurance, including public insurance, while the treatment which private hospitals provide is significantly influenced by the government's health care insurance system and by administrative guidance (Shinfuku, 2003). Furthermore, it is possible for private hospitals to have inpatients who are totally funded by the national and/or local governments, if the local governments officially designate them as substitutions for municipal hospitals.

With regard to psychiatric hospitals, except for university hospitals¹⁹, public hospitals had 363 patients who were involuntarily admitted (2% out of all the inpatients in public hospitals), whilst designated private hospitals had 1,262 involuntary patients (0.6% out of all the inpatients in these designated hospitals) on the 30th June 2013²⁰ (National Centre of Neurology and Psychiatry, 2014). Patients who have been involuntarily admitted to a hospital are funded by the local governments. Although the proportion of involuntary patients in public hospitals was more than three times larger than that of such patients in private hospitals, these private hospitals still had 76% out of all inpatients who were involuntarily admitted, namely public patients. With respect to special treatment, 33 public psychiatric hospitals ran emergency services (85% out of all these hospitals), whereas 667 private psychiatric hospitals did so (65% out of all private psychiatric hospitals) in 2014 (MoHLW, 2015).

As can be seen from the data above, according to the judgment of psychiatrists, public hospitals have a higher percentage of involuntary patients who are likely to harm others and/or themselves than private hospitals do. Moreover, public hospitals also provide a higher percentage of special treatment, which costs more than general treatment

allowing for a smaller number of staff for psychiatric care than for other medical care, psychiatric provision developed without sufficient staff (Okada, 2002, pp. 203-207).

¹⁸ As Gotoh (2012) argues, although it was relatively reasonable to have publicly-funded beds in private hospitals in the 1920s and 1930s, considering the shortage of financial resources for health care, the government continued to invest public expense into private psychiatric beds even after the Second World War, which understandably led to longer stays of patients and an overwhelming proportion of private hospitals in psychiatric provision.

¹⁹ I excluded the data on university hospitals here, as both private and public hospitals are included in the category 'University hospitals' in this report. The number of university hospitals was 83, which accounted for 0.05% of all the psychiatric hospitals in 2012.

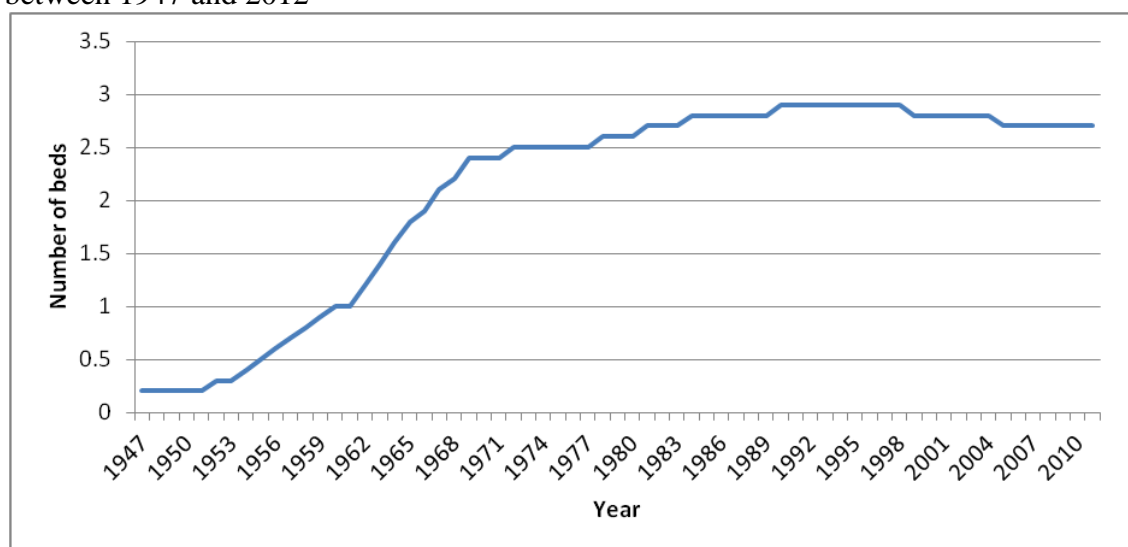
²⁰ This survey takes place on the 30th of June every year.

and requires a large number of staff members, than private hospitals. However, it is clear that private hospitals are still a significant contributor to public psychiatric care and advanced psychiatric treatment. In this vein, private hospitals in Japan are different from private hospitals in the countries where mental health care has shifted to community-based care.

Figure 1 shows the changes in the number of psychiatric beds between 1947 and 2012 in Japan. The growth between the 1950s and 1990s is in marked contrast with the decline in the number of psychiatric beds in some Western countries, where the decreasing trend started by the 1970s (Holloway and Sederer, 2011, p. 171).

Another characteristic of Japanese mental health care is long hospitalisation. In 2012, the average duration of patients' stay in psychiatric beds was 292 days (MoHLW, 2013a), which is significantly longer than, for instance, the average length of stay for adult patients with mental illness in England in 2011-2012 (53 days; median length of stay = 16 days; DoH, 2012).

Figure 1. Changes in the number of psychiatric beds in Japan per 1,000 population between 1947 and 2012



Source: Survey of Medical Institutions (Ministry of Health, Labour and Welfare) and Okada (2002)

1-2. Mental health care in contemporary Japan

This section describes some of the current characteristics of general health care, psychiatric institutions and mental health services, as well as the number of people who have used the services in Japan recently. This information can help to develop a better understanding of how Japanese people perceive, manage and experience stigma today. For instance, one may understand what is behind their perception, management and

experience of stigma by establishing in which institutions they receive treatment. Furthermore, information regarding the current characteristics of psychiatric institutions and mental health services, as well as the number of people who used the services can also help us to understand the background of the recent trends in social attitudes towards mental illness. For example, it is possible that the fact that many people are receiving psychiatric services influences the images of mental illness among lay people, which can lead to favourable attitudes towards mental illness.

1-2-1. Health care system

In Japan, the national government regulate the public health insurance system, which consists of approximately 3,500 insurers. Employees who work for large companies (those with more than 700 employees) and their family members under the age of 75 are enrolled in the coverage offered by their employers. In contrast, those who work for small or medium-sized companies (less than 700 employees) and their family members under the age of 75 are enrolled in the coverage offered by the Japan Health Insurance Association. The remaining population under the age of 75 is covered by ‘Citizens Health Insurance’, which is run by each prefecture. People aged 75 and over are covered by the ‘Health Insurance for the Old-Old’ plan by insurers established in each prefecture. All plans cover most health care services: hospital care, ambulatory care, approved prescription drugs, home care and dental care. All people with insurance must pay a co-payment of 30% for health services, except for children under three years old, whose co-payment is 20%, and those aged 70 and over with lower incomes, who have to pay a co-payment of 10% (Matsuda, 2013).

People can choose medical services freely, as there is no ‘family-doctor’ system in Japan²¹. However, 54% of people in Japan have a particular doctor whom they usually see when they are unwell (Eguchi and Deguchi, 2014), and these doctors may be regarded as their ‘family-doctor’. It is also common for people in Japan to search for information about a hospital or clinic, choose one, and go there to receive treatment when they become ill.

1-2-2. Psychiatric institutions and the services they offer

In 2012, the number of hospitals which had psychiatric beds stood at 1,653 (65% of which

²¹ There is no distinction between ‘general practitioner’ and ‘specialist’, since all medical students are trained as specialists and cover both primary and secondary care in Japan.

were psychiatric hospitals). This comprised approximately 20% of all hospitals in Japan in the same year, and the number of clinics whose services include psychiatric care was 5,739 (65% of which were psychiatric clinics); this constituted 6% of all clinics in Japan. In total, 54% of psychiatric hospitals had between 150 and 299 beds, whilst 9% of clinics had less than 20 beds²². Each psychiatric hospital had, on average, seven protection rooms, where patients are required to stay if they are likely to harm themselves/others (MoHLW, 2013a; National Centre of Neurology and Psychiatry, 2013b). Most (59%) psychiatric hospitals ran emergency services, whilst 94% of general hospitals lacked psychiatric emergency services (MoHLW, 2012a). With respect to the staffing pattern, there were 4 doctors, 21 nurses, 13 assistant nurses and 2 psychiatric social workers per 100 beds in psychiatric hospitals. The numbers of doctors and nurses were extremely low compared with those of general hospitals; there were 13 doctors, 46 nurses and 9 assistant nurses per 100 beds in general hospitals in 2012²³ (MoHLW, 2013b).

With regard to the prescription of medication, research has demonstrated that psychiatric polypharmacy, which refers to the concurrent use of multiple medication items by one individual, is not rare in various countries (Mojtabai and Olfson, 2010; Kukreja et al., 2013). With this said however, a comparative study among six Asian countries (Mainland China, Hong Kong, Japan, Korea, Singapore and Taiwan) found that polypharmacy and excessive dosing²⁴ in patients with schizophrenia were more common in Japan than in most of the other countries in the study (Ito et al., 2012). Although the proportions of polypharmacy and excessive dosing decreased both for acute patients and long-stay patients between 2001 and 2008, the rates of polypharmacy for acute patients

²² One of the characteristics of health care in Japan is that there are quite a few small clinics which have less than 20 beds, and which offer secondary care to some degree in addition to primary care (Ikai, 2010, pp. 20).

²³ Psychiatric care has traditionally been provided with a smaller number of staff than in general health care in Japan, mainly because of the psychiatric service exception, which is an administrative guidance allowing for smaller staff numbers in psychiatric provision than in general health care provision. According to this guidance (MoHW, 1958, guidance number.132), the number of doctors can be as low as one-third of the number of doctors in general hospitals and the number of nurses two-thirds that of nurses in general hospitals. Naka (2010) argues that the Japanese Medical Association and the Japanese Mental Hospitals Association have strongly resisted abolishing this rule, since mental health care in Japan depends upon private provision and thus doctors want to keep staff sizes small. Although the guidance was changed and psychiatric departments at general or university hospitals were required to have the same number of staff as in other departments, according to the revision of the Medical Care Law in 2001, psychiatric hospitals were still allowed to offer services with a smaller staff than in general health care. Because of this, the number of staff in psychiatric hospitals remains lower than that of staff in other health care institutions today.

²⁴ The authors defined polypharmacy as the concurrent use of more than one antipsychotic drug and excessive dosing as > 1000 CPZeq mg.

and long-stay patients were 51% (cf. average rate = 43%) and 66% (cf. average rate = 44%) respectively in 2008, whereas the rates of excessive dosing for acute patients and long-stay patients were 15% (cf. average rate = 12%) and 18% (cf. average rate = 18%) respectively in the same year in Japan. Polypharmacy and excessive dosing in psychiatric care has recently come to be regarded as a problem in Japan; indeed, the National Centre of Neurology and Psychiatry (2013a) issued a guideline in which they advised that doctors should reduce the number and amount of medication in psychiatric care when appropriate. Although there are no statistical data regarding the details of the treatment which psychiatric patients received, it is expected that drug treatment is the most common treatment in psychiatric care and counselling is relatively rare. This is because counselling is not covered by the national health care system, which means that it is quite expensive, while drug treatment is covered by the system.

There are also services for people with mental illness other than medical care: there were 1,422 care homes and group homes, 2,803 centres offering aid in everyday life or offering job training, 1,419 psychiatric hospitals and clinics which offered day care, and 1,463 psychiatric hospitals and clinics which had visiting nurses in 2012 (National Centre of Neurology and Psychiatry, 2013).

1-2-3. Numbers of people who used health and/or welfare services

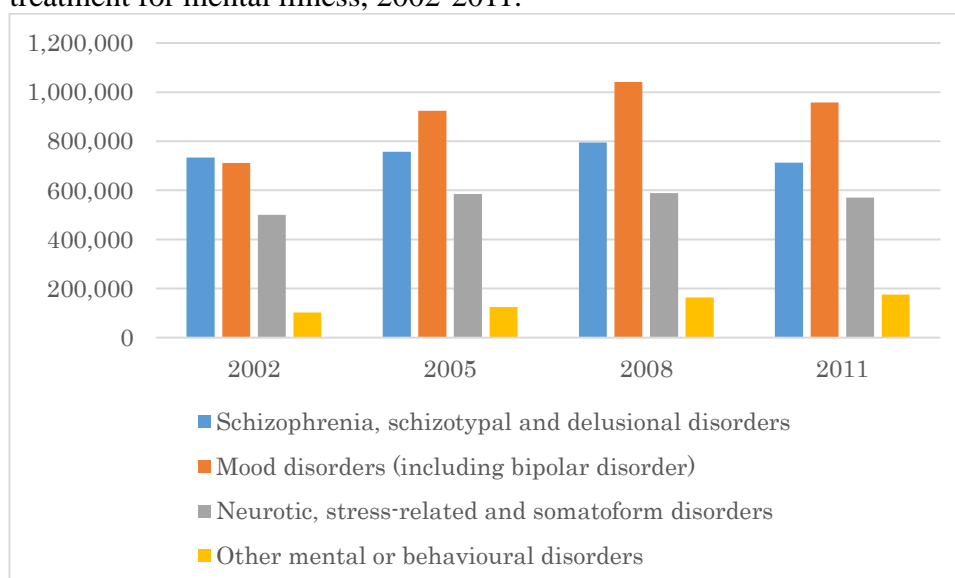
Figure 2 illustrates the trends in the estimated total number of patients who were continuously receiving medical treatment for mental illness on the day the government survey (Patient Survey) took place between 2002 and 2011. The estimated total number for 2002 was approximately 2 million (cf. population of Japan = 120 million), which peaked at approximately 2,600,000 in 2008. The most notable change is the increase in the estimated number of patients who received treatment for mood disorders, from 711,000 in 2002 to 1,041,000 in 2008. Figure 3 shows the changes in the estimated number of outpatients who received treatment either in hospitals or clinics for mental illness on the day the Patient Survey took place between 2002 and 2011. The total number was relatively stable over the period at approximately 200,000. The number of outpatients who received treatment for mood disorders occupied the highest proportion throughout the period, followed by the number of outpatients with schizophrenia or related disorders.

Figure 4 illustrates the trends in the estimated number of inpatients who were staying either in hospitals or clinics on the day when the survey took place for mental illness over the same period. The majority (approximately 80%) of the inpatients were

those with schizophrenia or related disorders throughout the period, with a slight decrease towards 2011 (from 203,200 in 2002 to 174,100 in 2011). Although the details of treatment are unknown because of the lack of statistics, 53% of psychiatric outpatients stated that they were satisfied with the treatment they received, which is similar to the overall proportion of outpatients, including those who received treatment other than psychiatric care, who were satisfied with it (48%); in addition, 51% of psychiatric inpatients stated that they were satisfied, which is considerably lower than the overall proportion of inpatients who were satisfied with their treatment (68%; MoHLW, 2013c). One of the reasons for the low percentage of psychiatric inpatients who were not satisfied with the treatment they received may lie in the fact that smaller staff numbers take care of their patients than in general health care, as stated above.

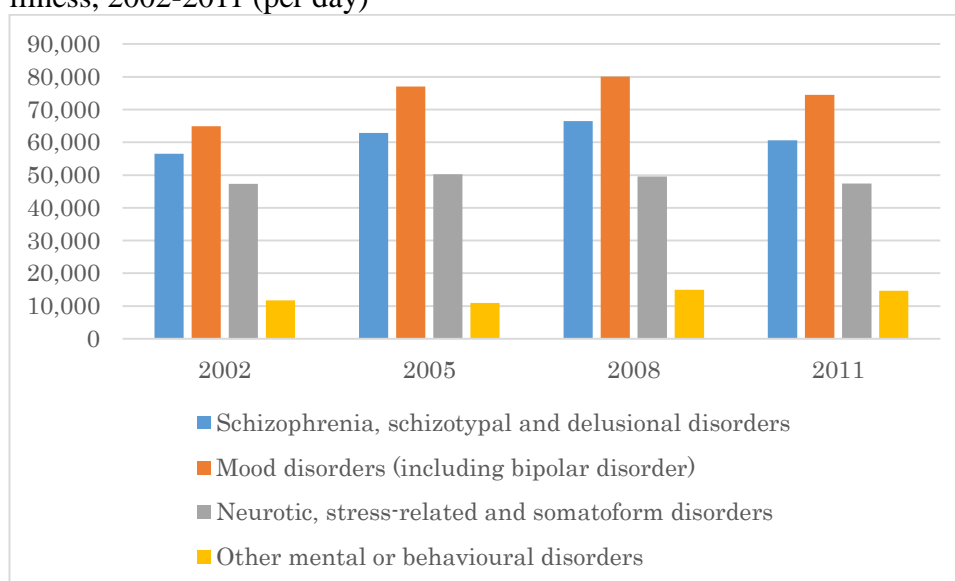
When looking at how many people with mental illness used services other than medical care in 2012, the number of people who lived in care homes or group homes for those with mental illness was 14,774, whilst 78,697 people used centres which offered them aid in everyday life or job training and 49,583 people used visiting nurse services. The number of people who were new to using psychiatric day care in June 2012 was 993 (National Centre of Neurology and Psychiatry, 2013).

Figure 2. Trends in the estimated number of patients who were continuously receiving treatment for mental illness, 2002-2011.



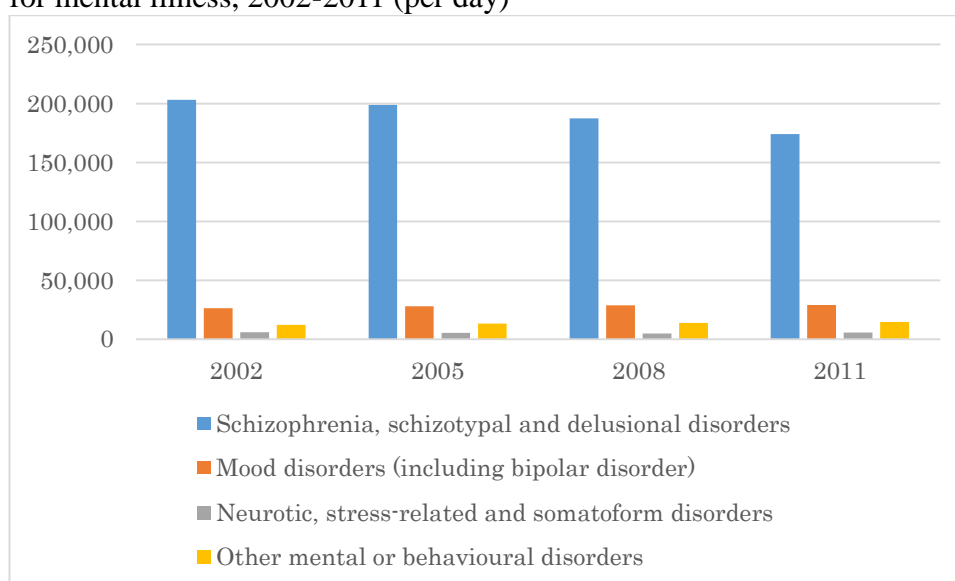
Source: Patient Survey, Ministry of Health, Labour and Welfare

Figure 3. Trends in the estimated number of outpatients who received treatment for mental illness, 2002-2011 (per day)



Source: Patient Survey, Ministry of Health, Labour and Welfare

Figure 4. Trends in the estimated number of inpatients who stayed in medical institution for mental illness, 2002-2011 (per day)



Source: Patient Survey, Ministry of Health, Labour and Welfare

1-3. Employment and financial status of people with mental illness

Work and economic situation are important factors in life. We shall now examine some statistical findings regarding employment and financial status among people with mental illness in Japan; indeed, the information obtained will help us to understand how people with mental illness live their lives and what is behind their perception, management and experience of stigma.

According to a 2011 national survey of people with a physical/intellectual

disability and/or mental illness which employed stratified random sampling (response rate = 59%), half of the participants under the age of 65 who had an identification booklet for mental illness²⁵ (52%) usually stayed at home during the day, whilst 20% of them joined a centre which offered them aid in everyday life or job training during the day (MoHLW, 2013d). Only 16% of them had a job. With respect to their income, in 2011 approximately half (52%) of them had an average monthly income of between 60,000 yen and 149,999 yen, whilst the proportion of those participants with the booklet and an average monthly income of over 149,999 yen was considerably lower (10%). The result for those over age 65 was similar. In total, 18% of the lower incomes participants with the booklet and under the age 65 were on benefits, which is similar to the proportion of people who were on welfare for the same reason all over Japan in 2011 (17%; MoHLW, 2013e). The proportion of lower income participants who had the booklet and were on benefits was only 7%, possibly because people over the age of 64 can receive a pension for older people. Another survey showed that the number of people who were on disability pension for mental illness in 2009 was approximately 500,000, which comprised 28% of all the people who were on disability pension in that year (MoHLW, 2010a).

With respect to employment, until 2006, the Law on Employment Promotion of People with Disabilities included only people with a physical disability or an intellectual disability. However, this Law was revised in 2006, which led to the inclusion of people with mental illness. The number of employees with mental illness increased from approximately 2,000 to 20,000 between 2006 and 2013 (MoHLW, 2008; MoHLW, 2013f). Furthermore, the Law on the Promotion of the Employment of People with Disabilities or Disorders 2006 prescribed that companies which have more than 50 full-time employees must employ more than one person with a physical or an intellectual disability and the proportion of employees with disabilities out of all employees must be over 2%. Since 2013, employees with mental illness have also been included in the proportion, according to the revision of the Law²⁶.

²⁵ People with mental illness can apply for an identification booklet for their illness, with which they can receive various preferential treatments such as reduction of taxes and of fees for public transport, when they have difficulties in everyday life or social life because of their illness. There are three grades for this booklet, from the third to the first; the first means more severe symptoms. According to a government survey, approximately 800,000 people had this booklet in 2013 (MoHLW, 2014a).

²⁶ There are no statistical data regarding the different types of work between the employees who are officially counted as those with mental illness by their employers and that of the employees without mental illness. Despite this however, it seems, from my personal contact with those affected and mental health professionals, that there are mentally ill people who are employed to do the same work as other employees. There are also mentally ill people who are employed to do less complex work

The government randomly sampled 13,100 companies which had more than 5 full-time employees from 18 industries; they also conducted a survey on the employment of people with disabilities/disorders in 2013 (response rate = 66%; MoHLW, 2013f). The survey revealed that 24% of the companies employed a person or people with mental illness²⁷. Of the employees with mental illness, people with bipolar disorder were most commonly employed (28%), followed by people with schizophrenia (24%). Most of these employees (83%) had the booklet for mental illness and 77% had become ill before they were employed. Half of them (48%) worked full-time with a contract that fixes the duration they can work at the company. The average monthly salary was 159,000 yen, which is lower than the overall average monthly salary of employees working for a company which had more than five full-time employees in the same year (260,000 yen; MoHLW, 2014b). In this survey, employees with disabilities/disorders also received a questionnaire about their experience at work (response rate of employees with mental illness = 53%). Seventy-two per cent of the employees with mental illness stated that they received support related to their illness at work so that they could work without a burden; indeed, the most frequently mentioned support was being allowed to take time off when they felt unwell (51%). However, the majority of the employees with mental illness (82%) were anxious about their future. Among these employees, the most common concern was whether they would be able to continue their job (72%).

We should be careful when interpreting data regarding the financial and employment status of people with mental illness, as these data essentially describe the situations of those in possession of the booklet; indeed, this signifies that these data are principally pertain to those with relatively severe symptoms. These data do not provide information about those with stable symptoms, and yet they provide a reasonably generalisable picture about the financial and employment status of people in possession of the booklet, considering the methods and response rates. Overall, the results suggest

than other employees. It appears that the second pattern, namely those who deal with less complex work than other employees, is more likely for mentally ill people who were employed than the first pattern. Some companies have a special recruitment policy for people with disabilities or disorders, including those with mental illness. The people who were employed under this type of recruitment seem to be generally assigned less complex work than people without disabilities or disorders.

²⁷ Although the number of people with mental illness who obtained a job continued to grow from 2009 to 2012, research has also shown that employee turnover for people with mental illness is high. For instance, Fukui et al. (2012) revealed that employee turnover was significantly higher in people with mental illness than in people with a physical and/or an intellectual disability between 2000 and 2009 in Osaka (average rate: people with a physical disability = 16%, people with an intellectual disability = 13%, people with mental illness = 75%).

that those with a booklet are usually out of work, and even those who have a job are on a low income.

1-4. Changes in law and policy

Whilst mental health care has long been hospital-centred, law and policy have been changed to promote community care since the 1960s in Japan. This section describes the major changes in law and policy related to mental health/illness, as these changes may affect social attitudes to mental illness and people with mental illness.

In 1965, the Mental Hygiene Law 1950 was revised to the Mental Hygiene Law 1965. The revision included an item that prescribes that public health centres can have workers who give people advice about mental hygiene and visit and help mentally ill people; the revision also dictated that the national and local governments must pay 50% of the cost of treatment for psychiatric outpatients. Thus, on the one hand, the revision aimed to spread knowledge about mental hygiene and to shift mental health care to community-based care. On the other hand, however, this revision also included an item which stipulates that when a police constable finds a person who is likely to harm him/her or others because of mental illness, the constable has to report it immediately to the prefectural governor through the head of the nearest health centre. Furthermore, the Law allowed a prefectural governor to hospitalise a mentally ill person temporarily (up to 48 hours) when it was urgent and the person was highly likely to harm him/her or others because of mental illness if he/she was not hospitalised immediately. Thus, the revision aimed not only to promote community care, but also to keep a close eye on mentally ill people who are likely to harm themselves or others and to hospitalise them if necessary. The Law includes items for surveillance by the police and the power of prefectural governors for compulsory admission. The major reason for this is that the revision was prompted by an incident in which an American Ambassador to Japan was seriously injured by a 19-year-old Japanese man with a diagnosis of schizophrenia (Murakami and Fujita, 1980).

In 1963, the Ministry of Health and Welfare, the Japanese Association of Psychiatric Hospitals and the Japanese Society of Psychiatry and Neurology were independently working towards a revision of the Mental Hygiene Law 1950 (Fujioka, 1980). Tsutomu Ezoe, who was a psychiatrist, stated that the progress of psychiatry, and particularly the introduction of pharmacotherapy, had revealed the possibility of establishing a system composed of early detection, treatment, return to society and after

care. It was thought that mental health care could shift from hospital-centred care to community care if the system was established. Yet, as it was impossible to establish such a system under the Mental Hygiene Law 1950, it was necessary to revise it, and so they worked towards revising the Law (Ezoe, 1964).

However, on the 24th of March 1964, Edwin Reischauer, the then American Ambassador, was stabbed in his thigh with a knife by a Japanese man who had previously been in a mental hospital and had a diagnosis of schizophrenia²⁸. The media were worried that ‘the mentally ill were at large’ and argued that the government should have taken steps to deal with the situation. The Minister of the Ministry of Health and Welfare suggested a revision of the Mental Hygiene Law 1950 on the 26th of March; the Bill aimed to increase the number of psychiatric institutions and staff. The National Police Agency also ordered each police prefecture to make a list of mentally ill people.

Meanwhile, young psychiatrists at the Tokyo Metropolitan Matsuzawa Hospital, which is one of the oldest public psychiatric hospitals in Japan (established in 1879), were astonished at how the Ministry of Health and Welfare and the National Police Agency were trying to deal with the situation. On the 2nd of May, they decided to disagree with the bill suggested by the Ministry, in cooperation with psychiatrists at other hospitals. The executive members of the Japanese Society of Psychiatry and Neurology were in the United States at the invitation of the American Psychiatric Association at that time. The young psychiatrists contacted the chairperson of the board of directors staying in the States and asked the executives to return to Japan. These young psychiatrists also called a journalist at the Asahi Newspaper to express their disagreement with the Bill. This was reported at the top of the front page on the 4th of May. Following this report, doctors, nurses and associations for families of people with mental illness joined the young psychiatrists’ movement. As a result, on the 7th of May, the Minister of the Ministry of Health and Welfare stated that they would not insist on a revision of the Law. The Ministry asked the Mental Hygiene Committee, most of whose members were mental health professionals, to give their opinions regarding a possible revision, and they devised a Bill based on the report presented by the Committee. As the revision also reflected the mental health professionals’ opinions, the Mental Hygiene Law 1965 came to include items not only for surveillance and custody of people with mental illness, but also for promoting

²⁸ The description of the incident and the subsequent developments were obtained from articles in the Asahi Newspaper (a newspaper with the second-largest circulation in Japan) between the 24th March 1964 and 5th of June 1965.

community care.

The Mental Hygiene Law 1965 was revised in 1987, with its name changed to the Mental Health Law 1987. This was the first major revision after 1965. The Mental Health Law 1987 prescribes that each prefecture can establish facilities for mentally ill people to promote their return to society (e.g. vocational aid centres). It also includes items for protecting the human rights of patients. This revision was made mainly because of national and international reaction to a scandal at a Japanese hospital.

The scandal was first reported on the 14th of March 1984. On this day, four members of the staff at Utsunomiya Hospital, a private hospital with 920 beds (of which 809 were psychiatric beds), were asked to present themselves at the police station to be questioned about two psychiatric patients' deaths in the previous year²⁹. During a specific incident, a 32-year-old male inpatient with schizophrenia had quarrelled with a male auxiliary nurse, holding the nurse's injured hand strongly at around 16:00 on the 24th of April 1983. The nurse took the patient into the next room and hit his back with a metal pipe. Although the patient ran away shouting 'stop it!', the nurse ran after him and hit him for 20 minutes. Soon after the incident, the patient vomited repeatedly and died at 20:30. His family was informed that he had died because of cardiac debility caused by an epileptic fit. The second incident happened on the 30th of December, when a 35-year-old male inpatient with alcohol dependence complained to his visitor that he wanted to be discharged from the 'terrible' hospital. The patient started to have a quarrel with another patient after the visitor had left, and three auxiliary nurses hit the patient's back and legs with bars. His condition took a sudden turn for the worse in the afternoon of the following day and he died at 18:35, after vomiting two litres of blood. The director explained to his family that he died because of vomiting blood caused by hepatocirrhosis.

Following an investigation, it was proved that the hospital also had many other problems. There were other victims of the staff's violence as well. Moreover, there was an insufficient number of staff, and only two doctors, including the director, who visited their patients weekly, despite the fact that there were some approximately 1,000 inpatients. No occupational therapists were present, yet inpatients were forced to work at paltry wages. As the director ordered some inpatients to work as medical staff, they gave medicine and even injections to other patients without any medical licence, which is illegal.

²⁹ The description of the incident and the subsequent developments were sourced from articles in the Asahi Newspaper between 14th March 1984 and 24th December 1986.

The scandal received a lot of attention in Japan. On the 22nd of March 1984, the Japanese Society of Psychiatry and Neurology decided to ask the Ministry of Health and Welfare to revise the Mental Hygiene Law 1965, and to reinforce the regulations on protecting the human rights of mentally ill people. The scandal also received international attention. On the 15th of August, the International League for Human Rights presented a document to the United Nations Commission on Human Rights, stating that the Japanese mental health care system, which is based on involuntary admission and isolation, violates the human rights of psychiatric patients. The document included descriptions of the staff violence against patients at Utsunomiya Hospital as an example.

The government continued to avoid making any definite comment on revision of the Law, although the Japanese Association of Psychiatric Hospitals demanded a revision on the 17th of January 1985. However, the government decided to revise the Law to improve the protection of the human rights of psychiatric inpatients in August. This was after a report on mental health care in Japan was submitted to the government by the International Commission of Jurists (ICJ) in July³⁰. In 1986, the Ministry of Health and Welfare published two reports. The first is a report on the return to society of mentally ill people, where it is stated that facilities to promote a return to society should be established. The second report pertains to a revision of the Law, which includes human rights issues. The Mental Hygiene Law 1965 was revised on the basis of these reports and its name was changed to the Mental Health Law in 1987.

One of the major revisions of the Mental Health Law took place in 2005, with the changes in mental health care policy, which are described in detail below. The revision changed the name of the Law to the Mental Health and Welfare Law 2005, which aimed to offer proper psychiatric services and reduce the number of long-stay inpatients. The Law also included the regulation that the names of hospitals would be published when they did not follow governmental advice to improve the quality of care and/or facilities. The Law also introduced a new system whereby psychiatric staff needed to reconfirm whether long-stay inpatients were remaining in hospital of their own free will.

In the same way as changes in law, mental health policy has also shifted to deinstitutionalisation, particularly after 2000. In 2002, the Ministry of Health, Labour and Welfare announced a change from hospital-based care to community care as one of the

³⁰ ICJ conducted a field survey on mental health care in Japan in May 1985, publishing a report in July (ICJ, 1985). In the report, they recommend revision of the Mental Hygiene Law 1965, promotion of community care and protection of the human rights of psychiatric patients.

aims of the mental health policy. In the government report from the same year, they stated that they would promote a reduction of psychiatric beds and the discharge of approximately 70,000 inpatients who could live in the community with appropriate services (MoHLW, 2002). The 2009 report stated that they would aim to reduce the number of inpatients with schizophrenia to 150,000 by 2015, which represented a reduction of 37,400 inpatients. In 2003, the government trialled a new programme in 16 cities, which aimed to enable people with mental illness to continue to live in the community. Since 2009, all 47 prefectures have taken part in this programme. One of the characteristics of this programme is that a team consisting of several mental health professionals, including psychiatrists, nurses, psychologists and psychiatric social workers, supports psychiatric inpatients in leaving hospital as soon as they can and continuing to live in the community. Patients can also receive the team's support after discharge for as long as they need, although principally the duration is fixed at six months. In terms of the rate of patients who left hospital using this programme, between 2006 and 2010, approximately 35% of all those in the programme successfully left (MoHLW, 2010b; 2012d).

The government also revised, several times, the medical treatment fees which they pay to medical institutions according to the treatment patients received. For instance, in 2008, the government created a new fee, which is paid to medical institutions when medical staff prepare the discharge of psychiatric patients who have stayed for more than five years with care and actually discharge them (MoHLW, 2008; Notification number 1168 and 1174). On practical and research levels, several local teams have provided Assertive Community Treatment (ACT) for people with mental illness as one of the programmes for promoting community care since 2002. Usami et al. (2010) conduct a one-year follow-up study of ten patients with schizophrenia who had received ACT and found that their psychiatric symptoms measured with the Brief Psychiatric Rating Scale showed a slight improvement, whilst their social functioning measured with the Global Assessment of Functioning significantly improved between the baseline and follow-up. Takagi et al. (2008) introduced ACT in Kyoto in 2004, revealing that the cost was lower than that of hospital-centred care. However, they pointed out that although there was an economic motivation for introducing ACT in Japan, it would be difficult to carry it out effectively for several reasons, including the limited number of psychiatrists with a proper understanding of community care. Overall, although some efforts have been made to promote community care recently in Japan, little evidence has emerged regarding the

effects of the programmes introduced on people with mental illness. It is also unknown whether the programmes have been leading to early discharge and establishment of community living of those affected.

1-5. Delay in deinstitutionalisation

As we have seen, law and policy have aimed to generate a shift to community-based care and some efforts have been made to enable the shift. Although there have been no drastic changes in psychiatric provision so far, the changes in law and policy have been gradually reflected in the number of psychiatric beds and demography of psychiatric patients. The number of psychiatric beds has been decreasing from 1996, although the pace is slow (from 360,896 in 1996 to 344,047 in 2011; MoHLW, 2012a). The number of psychiatric inpatients peaked at 369,000 in 2008, followed by a decrease to 332,700 in 2011 (MoHLW, 2012b). With respect to the pattern of admission and discharge, early discharge is becoming common; the proportion of the resident patients staying less than one year rose from 31% to 34% between 2004 and 2011, whilst the majority of the patients discharged in 2011 (64%) were those who had stayed in hospital less than three months (National Centre of Neurology and Psychiatry, 2005; 2012). However, there has been little change in the demography of the patients staying more than five years. The situations after discharge also show a marked contrast between the patients staying less than three months and patients staying more than five years; most of the former patients (75%) returned home after discharge, while 76% of the latter patients were discharged because of their deaths or a transfer to another hospital or another department in the same hospital (National Centre of Neurology and Psychiatry, 2012). This suggests that whilst early discharge is becoming common for new patients, discharge of old patients is still difficult.

Thus, psychiatric provision has not become community-based, although there have been slow changes. There are a number of possible reasons for this delay in deinstitutionalisation. The first is the high proportion of private psychiatric hospitals. Gotoh (2012) argues that since the major provider of psychiatric care has been private hospitals and the cost of care of public inpatients has been funded by the national government, there is an incentive for longer stays for public patients due to the financial interests of those running hospitals; there has been little motivation for private hospitals to aim to discharge public patients earlier. This argument holds true when looking at the pattern of psychiatric provision between the 1920s and the 1980s. In fact, as Gotoh (2012) points out, some 60% of psychiatric inpatients were public inpatients in 1928. Although

the rate of public inpatients gradually decreased, it was still 41% in 1985. However, the proportion of public psychiatric inpatients has started to decline rapidly since the 1990s, and public inpatients constituted only 0.6% of all psychiatric inpatients in 2013 (National Centre of Neurology and Psychiatry, 2014). The dramatic decrease was possibly caused by the introduction of voluntary admission in psychiatric care in 1987. Thus, most psychiatric inpatients are private patients nowadays, and yet the average length of stay is still long. This signifies that private psychiatric hospitals have an incentive to keep their patients longer, regardless of whether they are public patients or private patients.

The second possible reason is the multi-functional nature of psychiatric hospitals. With only a few welfare services for mentally ill people, 'psychiatric hospitals have continued to function as a special welfare facility' (Nishio, 2002, p. 378). These hospitals provide patients with services for returning to society (e.g. occupational therapy), and because said services are legally regarded as one of the medical services, it is difficult to establish a system whereby mentally ill people can receive welfare services in the community. Furthermore, under the pressure of deinstitutionalisation, private psychiatric hospitals have expanded their range of services to 'community care'. In fact, 83% of welfare homes are run by medical institutions such as psychiatric hospitals (MoHLW, 2012c).

Thirdly, stigma against mental illness has also prevented the promotion of community care. In some areas, when there is a plan to establish a facility for mentally ill people, residents in the community may well start a movement against the establishment, even nowadays (Nomura, 2010; Sasaki, 2006).

One might argue, however, that stigma is not a cause but a consequence of the delay in deinstitutionalisation. In other words, if lay people have many opportunities to make contact with mentally ill people by developing community care, lay people may not be likely to stigmatise people suffering from mental illness. This could certainly be true, particularly given the fact that countless studies have shown that an increase in contact with mentally ill people leads to less prejudiced attitudes and smaller social distance to them (Penn and Martin, 1998; Alexander and Link, 2003; Couture and Penn, 2003; Reinke et al., 2004; Corrigan et al., 2007).

However, research has also suggested that community care itself has little influence on social attitudes to mental illness. For instance, a study using representative samples of Luxembourg, where psychiatric care was organised in a custodial manner, and of Germany, where community care was advanced, found that social rejection and

feelings towards mentally ill people had been similar between these countries and the German participants had showed stronger rejection (Rössler, Salize and Voges, 1995). An English study also observed that residents of Bromsgrove, which was served by a traditional mental hospital, had been more tolerant than residents of Malvern, which had community-based services (Brockington et al., 1993). Furthermore, in the United States, where community care is advanced, ‘stigma in some ways intensified over the past 40 years even though understanding improved’ (DoH and HS, 1999, p. 8). Thus, one can say that stigma may be caused by a delay in deinstitutionalisation. Conversely, it is also true that advances in deinstitutionalisation have little effect on social attitudes and hence it can be said that stigma may be one of the reasons for delay in developing community care.

1-6. Summary

In this chapter, we have examined the historical background of mental health care, certain characteristics of contemporary psychiatric provision and service use, the employment and financial status of people with mental illness, changes in law and policy related to mental health/illness, and possible reasons for the delay in deinstitutionalisation in Japan.

Following its Westernisation at the end of the 19th century, Japan’s use of traditional treatment such as herbal medicine and moxa cautery declined, although traditional treatment is still alive nowadays to some degree. In the 1950s, the number of private psychiatric hospitals increased rapidly and many people with mental illness began to be treated in hospital. Today, Japan has a large number of psychiatric beds and mental health care has been hospital-centred; indeed, this is in contrast with community-based care in some Western countries. The major provider of mental health care in Japan has been the private sector from the 1920s to date. Psychiatric patients in Japan tend to stay in hospital longer and receive more medication – both in terms of number and dose – than those in other countries. In psychiatric hospitals, staff numbers are much smaller than in general hospitals, which may be one of the reasons why half of psychiatric inpatients were dissatisfied with the treatment they had received. In terms of the number of people who received psychiatric care, the number of outpatients with mood disorders increased, whilst that of inpatients with schizophrenia and related disorders decreased between 2002 and 2011.

Although recent times have seen an increase in the number of employed mentally ill people, according to a government survey, most of the people who had an identification booklet for mental illness did not have a job. Another survey revealed that those with the

booklet who were employed were receiving a lower salary than the overall average monthly salary of employees working for a company which had more than five full-time employees. The majority of the employees with mental illness were worried about whether they would be able to continue in their job.

Whilst mental health care has long been hospital-centred, law and policy have been changed in a shift towards community care. One of the most important revisions of the Laws related to mental health/illness took place in 1987, when the Mental Health Law 1987 prescribed the promotion of social inclusion for people with mental illness and the protection of their human rights, following a scandal at a psychiatric hospital. Since 2002, policies have also aimed to shift mental health care from hospital-based to community-based. The government have also been trying to reduce the number of inpatients with schizophrenia. Indeed, they introduced programmes for people with mental illness to live in the community, and some other programmes were also introduced by private organisations. However, because there is little evidence, it is unclear as to how the programmes have influenced people with mental illness and whether said programmes are leading to deinstitutionalisation.

So far, the pace of movement to community care has been slow. The statistics show that early discharge is becoming common for new patients, and yet discharge of old patients remains difficult. The possible reasons for the delay in deinstitutionalisation include the high proportion of private psychiatric hospitals, the multi-functional nature of psychiatric hospitals, and stigma against mental illness.

The next chapter concerns the concept of stigma, on which the present study depends. The chapter also reviews the findings of prior studies regarding social attitudes towards mental illness in Japan, as this is relevant to one of the present study's objectives.

CHAPTER TWO: CONCEPT OF STIGMA AND SOCIAL ATTITUDES TOWARDS MENTAL ILLNESS IN JAPAN

This chapter summarises how the concept of stigma has been used in research; it also provides the definition of stigma used in the present study and reviews the findings of studies on social attitudes towards mental illness in Japan.

2-1. The concept of stigma

The term stigma originally referred to a mark pricked or branded on the skin as punishment for a criminal (Walter, 1993, p. 471). One of the oldest sociological studies on stigma was conducted by Goffman (1963), who pointed out that earlier research on social psychology lacks clear definitions of stigma. He regarded stigma as ‘an attribute that is deeply discrediting’ (p. 4), but what was really needed for stigmatisation was not attributes, but language of relationships; someone can be stigmatised in social interactions and attributes in themselves do not cause stigmatisation.

Since Goffman’s work was published, the concept of stigma has been addressed by numerous studies, in various fields. For instance, on the database PsychInfo, there are 2,735 articles whose title includes the term stigma for the period between 2004 and 2014, excluding articles which use the term in a botanical context. These 2,735 articles vary with regards their themes, from physical or mental illness, to sexuality or cigarette smoking. Thus, the concept of stigma is employed in order to understand a particular phenomenon. However, it is often the case that research using this concept does not present a clear definition of stigma and that definitions of stigma differ between studies, even if they have a criterion for the concept. Of 410 articles which have been randomly selected from the 2,735 articles ($410/2,735=15\%$), 251 (61%) of these do not provide any definition of stigma, whilst the most frequently employed definition is that put forth by Goffman (48 articles or 12%). Although this may be because the meaning of the concept is regarded as clear and shared between researchers, one must show which definition of stigma is being adopted in a particular study so as to avoid misunderstanding.

At this point I would like to briefly summarise the main characteristics of recent theoretical works on stigma in order to explain which definition the present study adopts and the reasons for that. Whilst recent theoretical works have presented different definitions, roughly speaking, there are two characteristics in their definitions. First, stigma is regarded as a phenomenon which has social elements as well as individual elements. Link et al. (2004) argue that stigma consists of labelling, stereotyping,

separation, status loss, emotional reactions and discrimination, while stigma depends on power. In a more recent study, Link and Phelan (2014) regard stigma as a power which keeps people down, in or away. According to their concept, people use this power in order to exploit, control or exclude others when they have an interest in doing so. Approaches to the exercise of this power vary, from avoiding them to discriminating against them. Social aspects of stigma are sometimes called 'structural stigma', through which people with particular condition(s) are devalued and/or discriminated against. Examples include laws, social policy and institutional practices and so forth (Corrigan, Markowitz and Watson, 2004; Overton and Medina, 2008).

Second, the concept of stigma includes discrimination. In his argument regarding the usefulness of the concept of stigma when understanding mental illness stigma, Thornicroft (2006, pp. 180-192) points out that the major shortcomings of prior stigma theories are: (1) they pay little attention to structural and environmental factors, (2) they are not sensitive enough when it comes to understanding the feelings and experiences of the stigmatised such as people with mental illness, and (3) they are scarcely useful when thinking how it is possible to reverse stigma. In order to overcome these shortcomings, Thornicroft states that stigma can be seen as an overarching term containing problems of knowledge (ignorance), problems of attitudes (prejudice) and problems of behaviour (discrimination). This is because stigma is a sign of disgrace which can result in negative attitudes towards its bearer; moreover, the people with the sign can be targets of negative discrimination, behind which there is sometimes a lack of knowledge (Thornicroft et al., 2007). The authors feel that including causes and effects in the definition of stigma can help to establish an evidence base of effective interventions to reduce stigma. However, there is also opposition to the inclusion of discrimination in a definition of stigma. Drawing on literature reviews on HIV/AIDS stigma, Deacon (2006) argues that including discrimination in the definition of the stigma process narrows our understanding of the relationship between stigma and its effects. Indeed, there are two opposing schools of thought regarding the treatment of discrimination in a definition of stigma. However, as the aforementioned argument shows, whether discrimination should be included in the definition of stigma depends on the nature of each study. It may be better for theoretical research to separate discrimination, which can be seen as the behavioural consequences of stigma, from the definition of stigma. With this said however, if one aims to understand the experiences and feelings of the stigmatised, such as people with mental illness, discrimination should be included in the definition of stigma, as noted by Thornicroft

(2006) and Thornicroft et al. (2007). This is because the findings of prior research clearly show that discriminatory behaviour has devastating effects on the lives of people with mental illness (Thornicroft, 2006).

As we saw in the Preface, one of the objectives of the present study is to understand the perception, management and experience of stigma among people with mental illness in Japan. Therefore, this study essentially adopts the definition of stigma put forth by Thornicroft (2006), Thornicroft et al. (2007) and Thornicroft et al. (2009), which intends to understand the experiences and feelings of those who are stigmatised. In this definition, stigma is seen as comprising three elements: ignorance, prejudice and discrimination. As definitions of prejudice and discrimination vary between studies, it is necessary to provide a clear definition of them in this context. Thornicroft (2006) defines prejudice as a ‘preconceived opinion that is not based on reason or actual experience’ (p. 171). The present study does not employ this definition but prefers a definition forwarded by Corrigan et al. (2008, p. 35): ‘agreement with belief and/or negative emotional reaction’. This is because the term prejudice is more commonly used in the sense of the latter definition in Japan. With respect to the definition of discrimination, Thornicroft et al. (2009, p. 408) defined it as ‘unjust distinction in the treatment of different categories of people’ and asked their participants with mental illness whether they had been treated differently to other people because of their psychiatric diagnosis. Since this question seems to be clearer than the definition itself, the present study defines discrimination, based upon the questions in the study by Thornicroft and colleagues (2009), as ‘treating someone differently to other people because of their particular attribute or a label attached to them’ (p. 408).

2-2. Validity of employing the concept of stigma in a study in Japan

Whilst the term stigma is commonly used in English-speaking countries (Weiss, Ramakrishna and Somma, 2006), it is seldom used in everyday life in Japan and few studies have employed the concept. However, if one defines stigma as a concept which comprises ignorance, prejudice and discrimination, the concept can work for studies in Japan. This is because the terms prejudice (‘偏見’ *henken* in Japanese, with the first character meaning ‘biased’ and the second ‘views’) and discrimination (‘差別’ *sabetsu* in Japanese, with the first character meaning ‘differences’ and the second ‘distinctions’) are

commonly used both in everyday life and research. The meanings of these Japanese terms agree with the definitions of ‘prejudice’ and ‘discrimination’ put forth in the previous section. Similarly, the term ignorance (‘無知’ muchī, with the first character meaning ‘not’ and the second ‘knowing’) is also common in Japan. Considering these facts, it is reasonable to conclude that there will be no problem with employing these three concepts in the present study.

2-3. The concept of social attitudes

The concept of ‘attitudes’ has changed over the years. Whilst initial definitions in the 1930s were broad and encompassed cognitive, affective, motivational and behavioural components, they have lost breadth and have been reduced to evaluative components since the 1970s (Schwarz and Bohner, 2011). For instance, Voas (2014) defines an attitude as ‘an everyday judgement, a normative view on a specific matter’. The concept of social or public attitudes has been used in various studies, and yet its definition varies between said studies. Moreover, it is often true that studies employing the concept do not provide its clear definition. In defining social attitudes towards mental illness, the present study leans on Voas (2014), who sees it as ‘a normative view on mental illness in a specific society’. In the following, and in an effort to review prior studies on social attitudes towards mental illness in Japan, the present study includes the findings of studies which have surveyed how Japanese respondents think about mental illness and/or those affected (for instance, whether they regard persons with mental illness as unpredictable) and/or how they want to associate with people with mental illness (for example, whether they want to become friends with those affected).

2-4. Prior studies on social attitudes towards mental illness in Japan

There is a large body of literature on social attitudes towards mental illness in Japan. In this section, I will describe the findings of Japanese studies employing both representative samples and convenience samples, followed by a description of the findings of comparative studies contrasting Japan with other countries.

2-4-1. Studies employing representative samples

One of the earliest surveys on social attitudes towards mental illness which employed a nationally representative sample in Japan was conducted by the Cabinet Office (1971). This survey used multiple choice questions, some of which asked respondents about their

opinions on people with mental illness and on the treatability of this illness. Most of the participants (69%) stated that they felt ‘sorry for mental patients’ and only 16% of them were ‘afraid of mental patients’ (response rate = 84%). The proportion of respondents who thought that mental illness was treatable and that of respondents who did not think so were similar (38% and 31%, respectively). Zenkaren (the Japanese Federation of the Family of the Mentally Ill, 1984) assessed attitudes towards people with mental illness among representative samples of the general population in Tokyo, mental health professionals, members of the Committees of the government, and families of those with mental illness living in Osaka³¹ (n = 759, overall response rate = 76%). The survey asked respondents to what extent they agree or disagree with statements about opinions of people with mental illness (for example, ‘The mentally ill are fearful because they are unpredictable’). The community residents of Tokyo and families showed more stigmatising attitudes towards people with mental illness (such as regarding them as dangerous, incompetent and so forth) than the two other groups. The study also found that approximately half of the residents of Tokyo agreed with the statement ‘Mental hospitals are necessary because mentally ill people often turn violent or get excited and commit a violent crime’. A nationwide survey, conducted in 1997 and using the same questionnaire as the study in 1984 (n = 1,341; response rate = 67%; Zenkaren, 1998) showed that the proportion of respondents who agreed with the statement had decreased as a whole (36%). With this said however, 48% of those aged between 60 and 74 agreed with it.

There are also certain studies which have examined social attitudes towards specific mental illness diagnoses. Hanzawa et al.³² (2007a; n = 2,000) assessed respondents’ attitudes towards four vignettes (depression, depression with suicidal thoughts, early schizophrenia and chronic schizophrenia). These studies have also compared attitudes towards the depression vignette and towards the chronic schizophrenia vignette. In this survey, respondents were asked to what extent they agree or disagree with a number of statements about the vignette (for example, ‘I would not employ someone with this problem’). A vignette of a person with chronic schizophrenia

³¹ Mental health professionals (psychiatrists, psychiatric nurses, mental hygiene advisers, psychiatric social workers and occupational therapists) were randomly selected from a list of member names of the association they belonged to (e.g. Japanese Society of Psychiatry and Neurology). The authors also chose several Committees of the government and selected respondents randomly from lists of member names, although the authors do not state which Committees they chose.

³² In studies by Hanzawa et al. (2007a; 2007b), random sampling was continued until the total number of respondents reached the number they aimed for (reject rate unknown).

received significantly greater social distance than a vignette of a person with depression from respondents in almost all the question items³³. They thought that the person described in a schizophrenia vignette was significantly more unlikely to recover, more likely to be discriminated against in the community, and more unpredictable and dangerous than the depression vignette. The participants were also significantly more reluctant to hire persons with schizophrenia than persons with depression.

Itayama, Takada and Tanaka's (2012) study yielded similar results to that of Hanzawa et al. (2007a). They found that, in a survey on community attitudes towards persons with mental illness in three cities in Aomori prefecture, a vignette of a person with schizophrenia received significantly more frequent negative responses than a depression vignette (n = 179; response rate = 31%). This included agreement with the statement 'I would be ashamed if one of my family members was mentally ill'. Hanzawa et al. (2007b; n = 2,000) used the same method and respondents as in Hanzawa et al. (2007a). This study also showed that there were several significant differences between their respondents' attitudes to a vignette of a person with depression and suicidal thoughts and a vignette of a person with depression and without suicidal thoughts; they felt that the former was more unpredictable and more unlikely to recover; indeed, they were more reluctant to hire such a person than the latter. Tanioka et al. (2007) surveyed community attitudes towards and images of persons with mental illness in a district with a population of 27,000 (n = 293; response rate = 48%). In this survey, respondents were asked when they became aware of people with mental illness and what images they had of them, in addition to other questions regarding mental illness. With regards the question about images of those affected, respondents chose at least one answer from ten choices, including depressive or strange. The results showed that the most common image of persons with mental illness among respondents was 'strange' (20%), followed by 'fearful' (16%), whilst only 6% of them stated that persons with mental illness were the same as general people.

In a study by Yamazaki et al. (2012) (n = 994; response rate = 55%), respondents read one of two vignettes: a vignette of a person with depression, or that of a person with schizophrenia. They were asked to what extent they agree or disagree with statements including 'The person in the vignette can be as reliable as other people'. Over 90% of

³³ The concept of social distance was developed by Bogardus (1925; 1933) to measure the degree of closeness or acceptance individuals feel towards other groups. Small social distance signifies that individuals feel close to or they are willing to accept specific groups.

respondents regarded the symptoms of the person described in the vignette as ‘serious’, regardless of the type of vignette. These participants regarded the symptoms as ‘serious’ when they thought that the person in the vignette would need medical care. When asked whether the person in the vignette would harm others, 26% of the participants who read a vignette of a female with depression answered yes, whilst 38% of those who read a vignette of a male with depression answered yes; moreover, 49% of the participants who read a vignette of a female with schizophrenia and 67% of those who read a vignette of a male with schizophrenia answered yes. The differences were statistically significant between vignettes of persons with schizophrenia and those of persons with depression, as well as between the female schizophrenia vignettes and the male schizophrenia vignettes.

Studies on social attitudes towards mental illness have also examined the relationships between demographic characteristics and/or contact with mentally ill people in respondents, together with their attitudes. Oshima et al. (1989; n = 397; response rate = 81%) surveyed the community residents of a psychiatric hospital, which was known as being ‘open to the community’ and held a party every year which any community residents could join. Respondents were asked how much contact they had with people with mental illness and to what extent they would accept a person with schizophrenia (for instance, whether they would help the person when he/she had problems in everyday life). The results showed that a certain demographic was less concerned about the social distance between themselves and these patients. This demographic comprised males who had contact with mentally ill people, had sufficient knowledge about the hospital, and who had experienced changes in their impressions of people with mental illness after getting to know the patients of the hospital. The authors point out that active contact with those with mental illness, such as listening to them when they had problems and joining events at the hospital, showed a stronger association with smaller social distance, rather than passive contact such as having friends with mental illness.

Another study surveying the residents of Tokyo by Oshima (1992; n = 427; response rate = 43%), used the same scale as that used in studies by Zenkaren (1984) and Oshima et al. (1989); indeed, similar results were found. Active contact with people with mental illness was related to smaller social distance and there was no statistically significant difference in terms of social distance to people with mental illness between respondents who had passive contact with them and those who had no such experience. This study also revealed that there was an association between having experienced disability, disorder, serious illness and/or long hospitalisation, and smaller social distance

to people with mental illness. Here it is fitting to review the findings of another study (Oshima et al., 1992; n = 549; response rate = 78%), in which the authors compared community residents' attitudes towards mental illness in three areas of a city (one was the area where the residents opposed the establishment of a psychiatric medical centre in the city and the remaining two were areas where the residents had not opposed it). Indeed, this study used the same scale as that employed by Oshima et al. (1989), with the results of the latter mirroring those of Oshima (1992).

On the other hand, Ikeda, Okumura and Oshi (1999) painted a somewhat different picture by comparing community residents' attitudes towards people with mental illness in Sapporo city, which is the biggest city in Hokkaido, the northern frontier of Japan, and Urakawa town, which is one of the smallest towns in Hokkaido (Bethel House is in Urakawa town³⁴; n = 357; overall response rate = 60%). In this survey, respondents were asked to what extent they agree or disagree with a number of statements regarding those affected and mental illness itself (for example, 'Mentally ill people can lead a social life as long as they receive enough treatment and rehabilitation'). The results showed that there were no significant differences in terms of attitudes towards those with mental illness between respondents who had a lot of contact with those affected and respondents who had little contact with them in Sapporo city. With this said however, in Urakawa Town, respondents with more contact significantly more frequently showed favourable attitudes to those affected.

With respect to recent findings, Taneda, Morita and Nakatani (2011) surveyed attitudes towards people with mental illness among community residents in Urakawa Town (response rate = 21%). Respondents were asked to what extent they agree or disagree with certain statements about mental illness, those affected, and contact with them, such as 'I would disagree if someone with mental illness moved into my neighbourhood'. The findings showed that respondents who scarcely had contact with those suffering from mental illness and respondents who used, knew or helped to run the services Bethel House offered tended to show smaller social distance to those with mental illness than respondents who only had passive contact and respondents who had intensive

³⁴ Bethel House was founded in 1984 by clergy, social workers and volunteers as a living facility in the community for discharged psychiatric patients. Bethel House has grown over the past three decades to have several group homes, over 150 members and supporters, and a welfare shop. Bethel is now a non-profit organisation yielding several million yen in annual revenue. The history of Bethel and the lives of the members at Bethel are described in detail in the anthropological work of Nakamura, K. (2013).

contact, including those caring for people with mental illness such as medical staff.

Koyama et al.³⁵ (2011; n = 2,000, of which 1,500 data were analysed for this study) examined respondents' images of mental illness using a semantic differential scale, which measured the connotative meaning of objects, words and concepts. In this survey, for example, words such as 'lazy' and 'hard-working' were shown to respondents, who were then asked which word would be more suitable to depict mental illness. The findings showed that male gender, lower education and having no experience of contact with mentally ill people were associated with negative images about them. Kido et al. (2013) examined the relationship between social capital and stigma against people with mental illness in Tokyo (n = 516; response rate = 28%), using a translated version of Link's Devaluation-Discrimination Scale (Link, 1987; Hasui et al., 1999; Shimotsu et al., 2006). This scale asks respondents to what extent they agree or disagree with statements about 'general views on people with mental illness' (for example, 'Most employers will hire a formal mental patient if he or she is qualified for the job'). Social capital was defined as structural social capital, which consists of relationships, networks, associations and institutional structures which link people together, and cognitive social capital, which consists of values, norms, reciprocity, and so on. Social capital was measured by asking whether respondents participated in one or more voluntary organisations and by enquiring as to whether they thought people can be trusted and whether people try to be helpful. The results showed that respondents who agreed with the statement 'generally speaking, people can be trusted' and those who agreed with the statement 'generally speaking, people try to be helpful most of the time' showed significantly lower stigma scores than those who did not. In addition to this, there were no significant associations between areas and the stigma scores of respondents.

Overall, the findings of the studies in this section suggest that many Japanese people are prejudiced against mental illness, and this trend does not seem to have changed dramatically since the 1980s. In particular, the vignettes with severe symptoms, such as hallucinations and suicidal thoughts, more frequently received stigmatising responses than vignettes with less severe symptoms. The results of the studies also suggest that those who have contact with mentally ill persons are more willing to accept those affected than people who have little or no contact. In particular, active contact, not passive contact, seems effective in reducing social distance. However, this is not always true. In fact,

³⁵ In a study by Koyama et al. (2011), random sampling was continued until the total number of respondents reached the number they aimed for (reject rate unknown).

Taneda, Morita and Nakatani (2011) found that respondents who had frequent contact with those affected showed greater social distance to them than respondents who had little contact. This suggests that intense and frequent contact can lead to hope for greater social distance.

Methodologically speaking, although all the studies mentioned in this section employed nationally or locally representative samples, we should be careful when interpreting the results of the studies with a low response rate, as these samples might be biased. Furthermore, we should also be aware that most of the studies used different scales when comparing their findings.

2-4-2. Studies using convenience samples

(a) Review study

Ando et al. (2013) systematically reviewed 19 studies which examined mental-health-related stigma in Japan (published since 2001), most of which were quantitative surveys and used convenience samples. With the exception of two, the studies differed in terms of the scales they used to gauge respondents' attitudes towards mental illness. The findings of the review showed that mental illness was considerably stigmatised, with schizophrenia being more stigmatised than depression. Prejudice related to inabilities, dangerousness and unpredictability of persons with schizophrenia seemed to be strongly associated with negative attitudes. The general public often lacked accurate knowledge about mental illness; they more often preferred to think of the causes as psychological factors including weakness of character than as biological factors. Psychiatric staff generally exhibited less negative attitudes towards patients with schizophrenia than the general public and physicians with years of experience in psychiatric care, with the latter being negatively correlated to negative attitudes.

With regard to studies other than those included in the review by Ando et al. (2013), broadly speaking, there are two types in terms of the sample used: studies concerning the attitudes of general medical staff and/or mental health professionals and those focused on attitudes of students. The major findings of the individual studies are shown below.

(b) Individual studies whose sample includes mental health professionals

Kitaoka (2001) compared attitudes towards persons with mental illness among

community residents (n = 181, response rate = 26%), students of an upper secondary school (n = 300, 95%), local welfare commissioners, and members of four volunteer groups (n = 260, 79%) as well as the psychiatric staff of three hospitals (n = 219, 93%) in a city³⁶. This survey used the Attitudes towards Mental Disorder Scale (Higashiguchi, Morikawa and Nakagawa, 1997), which asks respondents to what degree they would accept someone with mental illness (for example, a spouse or a neighbour) and what images they have of those affected (respondents are asked to what extent they agree or disagree with statements such as 'The mentally ill are likely to commit a crime'). Generally speaking, the more respondents had contact with people with mental illness, the smaller the social distance. However, psychiatric staff showed almost the same level of social distance as the community residents and students, which was significantly higher than the level of social distance of local welfare commissioners and volunteers.

Matsumoto (2003) investigated the images of mental illness held by nurses working at a public psychiatric hospital and student nurses at a public school (n = 82). The authors asked these participants whether they are prejudiced against people with mental illness and employed a semantic differential scale (for instance, 'close' or 'distant'). In total, 45% of respondents stated that they were prejudiced against people with mental illness, whereas 17% stated that they were not prejudiced against them. There were no statistical differences in terms of self-reported prejudice between those who had worked at a psychiatric department and those who had not. Respondents who stated that they were prejudiced against people with mental illness were, however, significantly more likely to regard mental illness as gloomy or difficult to understand than those who stated that they were not prejudiced against them. Hoshigoe (2005) examined images of mental illness among 132 student nurses in the third year of a nursing school. These respondents had just finished training in hospital, including training for psychiatric care. The study also surveyed 150 student nurses in the first year of the same school by using a semantic differential scale (for instance, 'weak' or 'strong') and by asking about levels of acceptance of a person in a schizophrenia vignette (for example, whether they would hire him/her). Student nurses in the third year were significantly more reluctant to have direct contact with the vignette person, whether it be lending a room to him/her, or their daughter/son marrying him/her than the student nurses in the first year. Seventy per cent

³⁶ In this study, community residents were randomly selected. All the local welfare commissioners in the city were invited to the study and other groups (students, volunteers and psychiatric staff) were convenience samples.

of the students in the third year answered correctly that the vignette person suffered from schizophrenia and half of them (55%) stated that he would not recover, whilst 57% of the students in the first year stated that he suffered from a neurotic disorder and most of them (72%) thought that he would recover.

In a vignette survey, Shimono et al. (2012) compared the levels of acceptance of a person with schizophrenia among nurses working at a psychiatric emergency department ($n = 22$), those working at a psychiatric long term care department ($n = 19$) and those working at a general department ($n = 28$) of a hospital (overall response rate = 55%). The results revealed that (1) nurses working at the psychiatric long term care department were significantly more likely to state that the vignette person's problems were not real medical illness and that they would not like to become a neighbour of the vignette person than those working at a psychiatric emergency department, (2) when compared with those working at the psychiatric emergency department, nurses working at the general department tended to state significantly more frequently that the vignette person's problems did not constitute a real medical illness, they would not like to spend an evening socialising with the vignette person, and that they would not like to become a close friend of him/her, and (3) there was no significant difference between nurses at the psychiatric long term care department and those at the general department in terms of levels of stigma.

Yoshioka and Nakane (2006; response rate = 35%) surveyed 360 psychiatric social workers, 334 occupational therapists, 258 general nurses and 172 psychiatric nurses through several academic associations using a similar questionnaire to that used in a study by Hanzawa et al. (2007a). The findings showed that these professionals had, generally speaking, exhibited less stigmatising attitudes towards persons with schizophrenia or depression than the general public, although the trends were similar between these professionals and the general public when it came to the likelihood of voting for a politician with depression or schizophrenia; indeed, most of the mental health professionals, except for psychiatric social workers, stated that they would not vote for such a politician. The responses from both general and psychiatric nurses to the question regarding the unpredictability of people with schizophrenia were similar to those of the general public, with more participants stating that people with schizophrenia were unpredictable.

Overall, the results of the studies on attitudes towards mental illness among general and mental health professionals are mixed. Whilst Yoshioka and Nakane (2006)

found that mental health professionals had shown less stigmatising attitudes than the general public, Kitaoka (2001) found that psychiatric staff had shown almost the same level of social distance as the community residents and students. Furthermore, other studies showed that attitudes towards mental illness differed between student nurses and psychiatric nurses. The findings of the study by Hoshigoe (2005) – namely that third-year students showed higher levels of stigma than the first-year students – suggest that an increase in knowledge regarding mental illness can lead to a stigmatising attitude. Shimono et al. (2012) found that nurses working at a psychiatric emergency department had shown smaller social distance to persons with schizophrenia than those working at a general department and at a psychiatric long term care department. This signifies that knowing how to deal with patients with acute or severe symptoms on a practical level may lead to less stigmatising attitudes.

(c) Individual studies with a sample of students

Yamaguchi and Mino (2008) surveyed students at two primary schools (n = 102; response rate = 100%), one secondary school (n = 65; 95%), four upper secondary schools (n = 289; 97%) and three universities (n = 209, of which 24% were learning social welfare; 97%). This survey used a translated version of Pinfold et al.'s (2003) scale, which comprises four factual statements (for example, 'Mental health problems are caused by stress'), five attitude statements (for example, 'People with mental health problems are unpredictable'), all rated 'agree', 'disagree', 'unsure', and four social distance rating scales (for example, 'I would be afraid to talk to someone with mental health problems'), rated by asking to what extent respondents agree or disagree with the statements. Overall, university students exhibited less stigmatising attitudes towards people with mental illness than their younger counterparts. For instance, 45% of the university students disagreed with the statement that people with mental illness were dangerous, whilst 33% of primary school students, 28% of secondary school students and 28% of upper secondary school students did so. The responses of primary school students and those of university students generally showed considerable differences, and this trend was particularly true for the likelihood of becoming friends with people suffering from mental illness; 36% of primary school students thought that they would be able to become friends with them, whereas 60% of university students thought so. These results suggest that younger people are more prejudiced against those with mental illness.

Kamiyama and Takeda (2009) surveyed 84 students who attended lectures on

psychopathology at a university. They used a questionnaire developed based on the findings of previous studies. The questionnaire comprised a section regarding respondents' personality (developed based on Tokyo University's Egogram), where they were asked 60 questions such as 'Do you accept others' opinion?' There was also a section dedicated to respondents' attitudes towards mental illness, including 21 questions, rated 'yes' or 'no' (for instance, 'Can you become friends with those with mental illness?'). The findings showed that 14% of respondents thought that they had been strongly prejudiced against people with mental illness. The students who had no or little contact with people suffering from mental illness were significantly more likely to state that they were strongly prejudiced against them than those who had contact with them. The authors also examined the effects of personality on prejudice against those suffering from mental illness and revealed that the students whose personalities were classified as 'careless' or 'inconsiderate, critical and offensive' types were significantly more likely to report that they were strongly prejudiced against people with mental illness. Takao, Suzue and Jitsunari (2008) examined the attitudes and images held by 661 undergraduates who were studying social welfare at 6 different universities towards persons with physical disabilities, intellectual disabilities or mental illness, using three vignettes (response rate = 94%). The authors used a modified version of Hoshigoe's (2005) scale. The vignette of a person with mental illness received significantly greater social distance than that of a person with a physical or intellectual disability. Respondents who had contact with people suffering from mental illness showed significantly smaller social distance than those who did not.

Moro and Shimatani (2010) surveyed attitudes towards mental illness among 96 undergraduate students, 19 post graduate students and 198 young adults (details are unknown except that these adults were not students at the time of the survey). The authors used their own questionnaire developed based on the findings of previous studies. In the questionnaire, respondents were asked a number of questions including some regarding their knowledge of mental illness and some regarding their contact with people suffering from mental illness, rated 'yes' or 'no'. Respondents were also asked to what extent they would accept a person with a history of psychiatric hospitalisation (for instance, as a co-worker). The findings showed that respondents who had more knowledge about mental illness and contact with people suffering from it showed significantly smaller social distance to persons with a history of psychiatric hospitalisation than those who did not. The authors also conducted five qualitative interviews and found that there were two

patterns in the interviewees' attitudes. Those who had considerable knowledge about mental illness and/or contact with those affected were reluctant for one of their family members to date or marry a person who had stayed in a psychiatric hospital before; however, these interviewees did not care about having him/her as a neighbour, colleague, tenant or employee. The interviewees who had little knowledge about mental illness and contact with those suffering from it were willing to accept him/her in all the imaginary situations, including as a family member, as long as they acknowledged that the person with a history of psychiatric hospitalisation had made efforts towards social adjustment and the person did not have a criminal record. This study revealed mixed findings regarding whether knowledge about mental illness can lead to favourable attitudes towards persons with mental illness. The results of the questionnaire survey revealed that this held true, whilst those of the qualitative interviews showed that the interviewees with a vast knowledge of mental illness were more reluctant to associate with those affected by mental illness in a close relationship than the interviewees who knew little about mental illness.

Sakano et al. (2010) surveyed 974 undergraduate students from several universities (response rate = 97%), using three vignettes: depression, schizophrenia and asthma (these vignettes were randomly assigned to respondents). Respondents were asked their opinions about the vignette person (for instance, 'The person is difficult to talk to'), rated 'strongly agree', 'agree', 'disagree', or 'strongly disagree'. The students who read the schizophrenia vignette showed the highest level of stigma. The student nurses showed less stigmatising attitudes towards the vignettes with mental illness than students in other areas such as humanities and social sciences.

The findings of the studies on students' attitudes towards mental illness are generally consistent in that respondents who had contact with people suffering from mental illness showed less stigmatising attitudes than those who had no or little contact. Two studies (Kamiyama and Takeda, 2009; Yamaguchi and Mino, 2008) showed that age and personality might influence respondents' views on mental illness.

2-4-3. International comparative studies

Kurihara et al. (2000) surveyed office workers in Bali (Indonesia, n = 77) and Tokyo (n = 66) using Link et al.'s (1989) Devaluation-Discrimination Scale, which was designed for assessing the extent to which respondents would believe that most people devalue or discriminate against persons who have received psychiatric treatment. The authors also

used five brief imaginary case study vignettes designed to examine attitudes towards people with mental illness (three schizophrenia vignettes, one depression vignette and one obsessive-compulsive disorder vignette). Respondents were asked their opinions about the vignette person (for instance, whether they thought the person was abnormal), rated either 'yes' or 'no' or on a four-point scale, depending on the question. The office workers in Tokyo were significantly more likely to perceive persons with schizophrenia as being abnormal and to express greater hope for social distance to them than respondents in Bali. Respondents in Tokyo were also significantly less likely to think that they too would suffer from schizophrenia in future. They also tended to be less optimistic about the recovery and social readjustment of persons with schizophrenia than their counterparts. However, Balinese respondents were significantly less optimistic about recovery from depression and perceived persons with depression and those with obsessive-compulsive disorder as being more dangerous than the participants in Tokyo.

Kurumatani et al. (2004) compared the knowledge, beliefs and attitudes regarding schizophrenia of primary school teachers in Japan (n = 129, response rate = 76%) and primary school teachers in Taiwan (n = 150, 78%). In this survey, respondents were asked their opinions on the diagnosis, cause, effective coping behaviour and possible attitudes (how people would treat him) regarding a vignette of a 15-year-old boy with schizophrenia. The Japanese teachers had significantly less knowledge about schizophrenia and were significantly more likely to think that children with schizophrenia would be stigmatised by their parents/neighbours than the Taiwanese respondents. The largest proportions of both Japanese (79%) and Taiwanese (78%) teachers regarded the cause of schizophrenia as stress from personal relations, whilst the Taiwanese teachers significantly expressed more preference for 'heredity' (Japanese = 9% vs Taiwanese = 37%) and 'weakness of character' (29% vs 62%) than the Japanese teachers.

Griffiths et al. (2006) compared reactions to a depression vignette, a depression with suicidal thoughts vignette, an early schizophrenia vignette, and a chronic schizophrenia vignette of the Japanese and Australian community residents (n = 3,998 in Australia; n = 2,000 in Japan). In this survey, respondents were asked to what extent they agree or disagree with a number of statements about the vignette (for example, 'I would not employ someone with this problem'). The Japanese respondents generally showed significantly greater stigma against persons with mental illness than the Australian respondents, and the Japanese respondents were significantly more likely to think that the person in the vignette was suffering from a personal weakness and the problem was not a

real medical illness than their counterparts. In both countries, the proportions of the participants who stated that they would not vote for persons with chronic schizophrenia were significantly higher than those of the participants who stated that they would not vote for persons with depression, although the proportions were significantly different between the two countries (depression: Australia = 30%, Japan = 58%; chronic schizophrenia: Australia = 46%, Japan = 74%). In the same survey, respondents in both countries were also asked about possible causes of the symptoms of each vignette person (Nakane et al., 2005). Overall, whilst the Japanese respondents were more likely to think of the causes as weakness of character than their counterparts, the Australian respondents were more likely to regard the causes as a virus or infection, allergy, or inherited or genetic factors than the Japanese respondents. Respondents in both countries were also asked what, in their opinion, was wrong with the vignette person (Jorm et al., 2005). The findings showed that the Japanese respondents more frequently tended to describe the problems of the vignette person as psychological/mental/emotional than the Australian respondents, who were more likely to use psychiatric labels to describe the problems than their counterparts, particularly for the depression vignette.

Masuda et al. (2009) compared the attitudes of Japanese international students and US students at a university in Nevada towards persons with mental illness, using the Community Attitudes Towards the Mentally Ill Scale (CAMI; Taylor and Dear, 1981). Respondents were asked to what extent they agree or disagree with certain statements (for instance, 'No one has the right to exclude the mentally ill from their neighbourhood'). The Japanese students showed significantly higher scores in CAMI than the US students, which suggests that the Japanese students had more stigmatising attitudes towards persons with mental illness than US students. Haraguchi et al. (2009), on the other hand, found different results. They conducted a survey concerning knowledge of psychiatry and social distance to persons with schizophrenia amongst Chinese rehabilitation workers at a hospital specialising in physiotherapy, first-year medical students, and first-year physiotherapy students (n = 347). There was also a comparison of Japanese rehabilitation workers at a general hospital and first- and second-year students at a health and welfare school (n = 352). The authors used the Social Distance Scale-Japanese version (SDSJ; Makita, 2006) and a Chinese translation of the SDSJ, whereby respondents were asked to what extent they would accept a person with schizophrenia (for instance, as an employee), and the Knowledge of Illness and Drugs Inventory (KIDI; Maeda, Mukasa and Ogoh, 1992) as well as a Chinese translation of KIDI, graded as 'correct' or 'incorrect'. The

Chinese respondents showed significantly greater social distance in most question items and were significantly less knowledgeable about psychiatry than their Japanese counterparts.

Overall, most of the findings from these comparative studies suggest that Japanese people are more prejudiced against, and have greater hope for social distance to, persons with mental illness, particularly those with schizophrenia, or are less knowledgeable about mental illness than people in other countries. Prejudice against and greater hope for social distance to people with mental illness may be related to negative images of psychiatric departments or hospitals in Japan. Okamoto, Abe and Matsumoto (2002) surveyed student nurses' images of psychiatric departments ($n = 106$) and found that 51% of them had regarded psychiatric departments as 'depressive' before their training there. Kimata (1996) conducted a survey to study how community residents in Aichi prefecture ($n = 261$) viewed ten medical disciplines, including psychiatry. The respondents were asked to describe the images they had of each medical discipline freely in the questionnaire. The images of psychiatric departments or hospitals included 'dangerous', 'I don't want go there', 'squeamish', 'fearful', 'shame' and 'abnormal'. There were statistically significant differences in respondents' age and gender; older respondents were more likely to think that they do not want to go to a psychiatric hospital or department and to regard them as 'squeamish', 'fearful' and 'shame' when compared to younger respondents. In contrast, men were more likely to give the image 'dangerous' than women. We can see that the results of these two studies are similar to those of the studies on social attitudes towards mental illness, although it is unclear whether images of psychiatric institutions lead to negative images of people with mental illness or if images of people suffering from mental illness lead to less favourable images of psychiatric institutions.

With respect to methods, the studies using convenience samples generally differed in their scales. Therefore, although a review of these studies provides an overall sense of what Japanese people think about mental illness and those affected, we should be aware of their methodological differences when comparing the respective findings. It should also be noted that time trends in social attitudes towards mental illness are unknown, as there have been no longitudinal studies, either using representative samples or convenience samples, in Japan.

2-5. Social attitudes towards mental illness in the media

This chapter has reviewed prior studies on social attitudes towards mental illness, all of which employed a questionnaire survey. However, other types of studies have also been conducted on social attitudes towards mental illness. One of these studies include an analysis of newspaper articles. There are numerous studies across the globe that have addressed social attitudes towards mental illness by analysing newspaper articles, although there are few studies that have analysed Japanese newspapers. Briefly summarising the results, review studies have revealed that, between the 1950s and 2005, mental illness was consistently misrepresented, particularly with regard to the notion that people with mental illness are violent and dangerous (Klin and Lemish, 2008; Nairn, 2007; Pirkis et al., 2006; Sieff, 2004; Stout, Villegas and Jennings, 2004; Stuart, 2006; Wahl, 1992). Indeed, recent studies have also found the same result (Goodwin, 2014; Kesic, Ducat and Thomas, 2011; Murphy, Fatoye and Wibberley, 2013; Nawka et al., 2012; Nawková et al., 2012). Methodologically speaking, content analysis is often used in these studies. More detailed findings are presented in Chapter Five, along with a discussion of the results of newspaper article analysis in the present study.

2-6. Summary

This chapter summarised how the concept of stigma has been used in research; it also provided the definition of stigma that is used in the present study and reviewed the findings of studies on social attitudes towards mental illness in Japan.

The concept of stigma has been addressed in various studies, and yet the definition varies between said studies. The major characteristics of recent research on stigma place emphasis on social factors and the inclusion of discrimination. In order to understand the perception, management and experience of people with mental illness in Japan, the present study employs the definition of stigma put forth by Thornicroft (2006), Thornicroft et al. (2007) and Thornicroft et al. (2009), who state that stigma is comprised of three elements: ignorance, prejudice and discrimination. Although the concept of stigma is not familiar in Japan, these three components are common in Japan and therefore there will be no problems with employing the definition in the present study.

As for social attitudes towards mental illness in Japan, generally speaking, respondents showed greater social distance or higher levels of stigma to persons with severe symptoms than to those with stable symptoms. Moreover, respondents who had contact with people suffering from mental illness were more willing to accept those

affected. The findings regarding attitudes among mental health professionals were mixed, with some studies revealing that they are less prejudiced against those affected and one study finding that they showed almost the same level of social distance as the community residents. The attitudes of mental health professionals also varied between the departments of the hospital they worked for. On the other hand, the findings of the studies on students' attitudes towards mental illness were generally consistent in that respondents who had contact with people with mental illness showed less stigmatising attitudes than those who had no or little contact. International comparative studies found that, overall, Japanese people were more prejudiced against, and had greater hope for social distance to, persons with mental illness, particularly those with schizophrenia, or were less knowledgeable about mental illness than people in other countries. Most of the studies on social attitudes towards mental illness in Japan used different measures, and there have been no longitudinal studies.

Social attitudes towards mental illness have also been studied using analysis of newspaper articles. The results of these studies show that the reporting of mental illness is often related to violence. More detailed findings are presented in Chapter Five, where the findings of the analysis of Japanese newspaper articles in the present study are compared to the findings of prior studies.

In the next chapter, we will assess what is known about the perception, management and experience of stigma among those with mental illness by reviewing previous studies.

CHAPTER THREE: THE PERCEPTION, MANAGEMENT AND EXPERIENCE OF STIGMA AMONG PEOPLE WITH MENTAL ILLNESS

This chapter reviews the findings of studies on the perception, management and experience of stigma among people with mental illness.

3-1. Findings of quantitative studies

Whilst studies on stigma against people with mental illness have a long history, usually taking the form of attitudes surveys, research on stigma from the viewpoints of people with mental illness has received growing attention relatively recently. Indeed, many of these studies have now been conducted, particularly in Europe and the US. Most of the studies which are mentioned below, therefore, were carried out in European countries or the US. In Japan, however, as will be seen in the section ‘Studies on the perception, management and experience of stigma among people with mental illness in Japan’, there have been few such studies.

As one of the objectives of the present study is to understand the perception, management and experience of stigma among people with mental illness, the following three sub-sections describe the findings of prior studies on this subject. Following the definition of stigma in the present study, research examining the perception, management and experience of ignorance, prejudice and discrimination among people with mental illness has been included here. In this review, perception was defined as ‘what an individual thinks most people believe about the stigmatised group in general’ and ‘how each individual believes society views him/her personally because he/she is a member of the stigmatised group’ (LaBel, 2008, p. 414), management as strategies for coping with stigma and experience as being actually stigmatised. In the section on perception, I will also refer to studies using the concept of anticipation, since these studies define anticipation in the same way that perception is defined in the present study.

3-1-1. Perception of stigma

Studies using the concept of anticipation

Freidl et al. (2007) surveyed anticipation of stigma among 101 inpatients and outpatients with psychiatric or neurological disorders in Austria (45% with epilepsy, 14% with dissociative disorder and 42% with somatoform pain disorder). They used Link’s

Devaluation-Discrimination Scale (1987), which consists of 12 items asking respondents' opinions about the extent to which most people would accept a person who was in a psychiatric hospital as a friend, teacher, employee or care-taker of their children. This scale also covers whether a person with a history of psychiatric hospitalisation is seen as less trustworthy or less intelligent than others. The results showed that most of the respondents with somatoform pain disorder (79%) had agreed with the statements (1) most people would not hire a person with mental illness to take care of their children even if he/she had been well for some time and (2) most young women would be reluctant to date a man with mental illness. In contrast, the proportions of respondents with dissociative disorder who agreed with these statements were relatively low at approximately 40%. The majority of respondents with dissociative disorder (57%) agreed with the statements (1) most people think less of a person with a history of psychiatric admission and (2) once they know a person has stayed in psychiatric hospital, most people will take his/her opinions less seriously.

Angermeyer et al. (2004) examined the anticipation and experience of stigma in patients with schizophrenia or depression in Germany (N = 105, 49% with schizophrenia and 51% with depression), with anticipated stigma being measured by the extent to which respondents agreed with statements such as 'I believe that most people would not enter into a partnership with somebody who is mentally ill' (see the sub-section 'Experience of stigma' for the findings on experienced stigma). The results revealed that respondents had most frequently anticipated stigma in access to work (69% for people with schizophrenia and 82% for people with depression), although only the minority of them actually experienced stigma in this area (19% for people with schizophrenia, and 2% for people with depression). Those who lived in a small city felt significantly more strongly that they were avoided by others than those who lived in a large city. However, in a Polish study which surveyed 202 patients with schizophrenia or related disorders (Cechnicki and Bielańska, 2009; Cechnicki, Angermeyer and Bielańska, 2011), those who lived in large cities generally showed greater anticipated discrimination than those who lived in small cities or villages. In this study, anticipated discrimination was measured by the extent to which respondents agreed with statements about negative views on people with mental illness (for example, 'I think the majority of people do not want to have a mentally ill person as their partner') and by their answers to questions such as 'Should mentally ill people inform the employer about their illness?'

There are many other studies which have examined anticipation of stigma among

people with mental illness. The major findings of some of these studies alluded to in the next sub-section 'Management of stigma', as said studies assessed the frequency of concealment of illness and of stopping doing something for fear of stigma among those affected, both of which can be regarded as strategies for coping with stigma.

Studies using the concept of perception

Rosenfield (1997) assessed the perception of stigma in 157 service users at a rehabilitation programme for people suffering from chronic mental illness in the US (diagnoses not shown). In this study, perception of stigma was examined using Link's Devaluation-Discrimination Scale (1987; 1989). Of 157 respondents in Rosenfield's study, just over one-half of them believed that people with a history of psychiatric hospitalisation had been stigmatised. Perception of stigma was significantly and negatively correlated with respondents' life satisfaction; the greater the perception of stigma among these respondents, the lower the levels of satisfaction with life. The results of regression analysis suggested that perception of stigma reduced their satisfaction by compromising their self-worth and self-efficacy. However, specific services received, including vocational rehabilitation and structured activities, were significantly associated with higher levels of life satisfaction when stigma was controlled for. Sirey et al. (2001) surveyed 134 patients with depression in the US and found that lower levels of perceived stigma were associated with better adherence to the recommended medication regimen. In their study, perceived stigma was assessed with a modified version from Link's (1989) scale.

Chung and Wong (2004) surveyed 193 psychiatric outpatients (48% with schizophrenia or another psychotic disorder, 21% with bipolar disorder, 13% with major depression and 14% with anxiety disorder) in Hong Kong. In their study, perceived and experienced stigma were assessed with a modified scale from Link et al. (1991; 1997) and Wahl (1999a), asking respondents' opinions on what most people would think about a person with mental illness and experience of rejection. The majority of respondents reported perceived stigma in various areas, with 76% of them agreeing with the statement that most employers would not hire a person with a history of mental illness. However, the proportion of those who were actually rejected by others was lower than those who perceived stigma. For instance, the rate of respondents who had been turned down for a job for which they had been qualified because of their history of mental illness was 20%.

The authors also assessed coping strategies with the same scale, the findings of which will be mentioned in the next sub-section.

Rüsch et al. (2006) examined perceived discrimination and perceived legitimacy of discrimination among 60 women with borderline personality disorder and 30 women with social phobia in Germany and Switzerland. Perceived discrimination meant that respondents were aware of public prejudice and discrimination against them, whereas perceived legitimacy of discrimination meant that they thought such prejudice and discrimination were justified. The results showed that levels of perceived discrimination and perceived legitimacy of discrimination did not differ between those with borderline personality disorder and those with social phobia, although the former showed significantly stronger identification with the group of people suffering from mental illness. In a regression analysis, lower levels of perceived discrimination and perceived legitimacy of discrimination predicted higher levels of self-esteem and empowerment. The level of identification with the group of people suffering from mental illness was unrelated to self-esteem or empowerment. In a US study by Kleim et al. (2008) which measured perceived stigma in 127 patients with schizophrenia using Link et al.'s (1987) Devaluation-Discrimination Scale, perceived stigma was high among respondents, with the mean score being above the midpoint. Indeed, 64% of them endorsed the belief that psychiatric hospitalisation would be recognised as a failure. The authors also examined coping methods, and these findings will be shown in the next sub-section.

Rüsch et al. (2009) assessed ingroup perception (how respondents value a group of people with mental illness), group identification (how strongly respondents feel attached to the group), entitativity (perception of the ingroup as a coherent unit), perceived devaluation and discrimination, and behaviour towards pursuing one's own goals and hopes. The subjects were 85 US nationals with mental illness (61% with a life-time bipolar disorder, 53% with a life-time psychotic disorder and 30% with current major depression). The authors used Link's (1987) Devaluation-Discrimination Scale to assess perceived devaluation and discrimination. High group value and high entitativity predicted positive behaviour, such as educating others about mental illness and helping another person with mental illness. Helping was also related to lower levels of perceived discrimination. On the other hand, feeling more attached to the ingroup was correlated with poorer social performance in respondents who placed a low value on their ingroup. High levels of perceived discrimination, low group value and low group identification predicted keeping their mental illness a secret.

Yow and Mehta (2010) examined perceived stigma among 84 in- and outpatients with schizophrenia in Singapore. Perceived stigma was assessed using Link et al.'s scale (2002), which asks respondents' opinions on the extent to which they agree or disagree with statements indicating that most people devalue people with mental illness. Seventy-four per cent perceived stigma towards people with mental illness, particularly in job-related areas; 86% believed that applications from people who had received psychiatric treatment would be turned down and 79% thought that such people would not be hired to take care of children. Karidi et al. (2010) surveyed 150 outpatients with schizophrenia in Greece, finding that, overall, the majority of them perceived rejection from others; 80% of them did not think that someone would marry them and 67% thought that people would avoid them when they knew about their illness. However, among respondents who perceived rejection from others, the proportion of those who were actually avoided by others because of their illness was 33%, which was much lower than they expected.

Alvidrez, Snowden and Patel (2010) analysed data from a randomised pilot study in which Black people with mental illness participated; the findings revealed that men and more educated people showed significantly higher levels of perceived stigma than women and less educated respondents (n = 42, 79% with depression, 40% with post-traumatic stress disorder, 36% with other anxiety disorder, 29% with pain disorder and 10% with personality disorder; some respondents had more than one diagnosis). Perceived stigma was examined using Link et al.'s Devaluation-Discrimination Scale (1989). Maier et al. (2013) surveyed 74 former female in- and outpatients with anorexia nervosa in Germany and found that the majority of them (68%) had been criticised by their parents because of their illness symptoms and 77% had not believed that most people would treat people with anorexia nervosa like anyone else. Although 71% disagreed with the statement that most employers would not mind employing someone with anorexia nervosa as long as he/she is qualified for the job, only 18% had been rejected for a job because of their illness.

Zelst et al. (2014) examined stereotype awareness among 186 patients with psychotic disorder in the Netherlands and Belgium by assessing respondents' opinions regarding what most people believe about people with mental illness. In total, 71% agreed with the statement 'most people think less of a person who has been in mental hospital'; in addition to this, 66% agreed that most employers would not hire a person who once had a serious mental illness even if he/she was qualified for the job. Those who showed lower levels of stereotype awareness had higher levels of self-esteem. Kulesza, Raguram

and Rao (2014) investigated perceived stigma among 60 psychiatric patients in India. Most of their questions about perceived stigma asked for respondents' opinions on how others would react if they knew of the respondents' illness. The results revealed that levels of depressive symptoms were positively and significantly associated with levels of perceived stigma. Women significantly more frequently reported perceived stigma than men. In the United Kingdom, 202 people were asked about anticipated and experienced discrimination (47% with schizophrenia, 32% with depression and 20% with bipolar disorder); 93% of them stated that they expected to be treated unfairly in at least one area of life among 21 areas including friend relationships, employment, and dating (findings on experienced stigma in the sub-section 'Experience of stigma'). Over 70% of them reported anticipated discrimination from employers and colleagues. There were moderate but significant associations between (1) the severity of anticipated and experienced discrimination and (2) the number of areas of anticipated and experienced discrimination (Farrelly et al., 2014).

Quinn et al. (2014) examined anticipated stigma in the US, which is the extent to which respondents were concerned about mistreatment and devaluation from others if their concealed identity became known. The subjects were people with a concealed stigma (mental illness, substance abuse, experience of domestic violence, experience of sexual assault and experience of childhood abuse); the results revealed that people with mental illness, together with those with substance abuse, reported the greatest amounts of anticipated stigma among the groups ($N = 394$, 27% with mental illness). The mean scores for the mental illness and substance abuse groups were above the midpoint of the scale; they thought that they were likely to be denigrated and socially distanced by others if their illness or abuse became known. The authors also found a positive correlation between the level of anticipated stigma and that of psychological distress. In a Singaporean study by Ow and Lee (2015) which assessed perceived stigma and coping orientations among 80 patients with schizophrenia (findings on coping in the next sub-section), higher levels of perceived stigma were related to lower levels of self-esteem, poorer quality of life and higher levels of depressive symptoms. Perceived stigma was examined using Link et al.'s Devaluation-Discrimination Scale (2002). In regression, perceived stigma predicted lower self-esteem when gender and levels of depressive symptoms were controlled for; in addition, perceived stigma also predicted poorer quality of life when levels of depressive symptoms were controlled for.

Methodologically speaking, the majority of these studies employed the same

scale (Link, 1987; Link et al., 1989; 1997; 2002), while some studies differed in their scales. With this in mind, we should be careful when comparing their findings to others. However, although the studies included in this sub-section have some methodological differences, their findings seem to be quite consistent; many of the people with mental illness felt that those affected would be stigmatised by most people. Some studies also showed that higher levels of perception or anticipation of stigma were related to lower levels of self-esteem, quality of life, life satisfaction, self-efficacy and so forth. Although some other studies found that those with more severe symptoms had shown higher levels of perceived stigma than other respondents, it is unclear as to whether more severe symptoms lead to higher levels of perceived stigma or if higher levels of perceived stigma lead to deterioration in symptoms or whether they are interrelated.

3-1-2. Management of stigma

Link, Mirotznik and Cullen (1991) conducted a US-based study and examined the relationships between three coping orientations (secrecy, educating others about their situation and withdrawal) and demoralisation (how frequently within the six months before a follow-up interview respondents felt helplessness, hopelessness, sadness, low self-esteem and so on) and employment status among patients with schizophrenia or depression (n = 236). Secrecy and education had no significant additive effect on either demoralisation or unemployment, and yet to the extent that there was an effect, secrecy and education were correlated with a shift towards a worse outcome in demoralisation and unemployment. Adopting a coping strategy of withdrawal showed significantly harmful effects for both demoralisation and unemployment. Chung and Wong (2004) examined coping strategies with stigma, characterised as (a) secrecy, (b) avoidance and withdrawal and (c) advocacy and confrontation, among 193 psychiatric outpatients in Hong Kong (diagnosis details in the sub-section 'Perception of stigma'). While 66% stated that they waited until they knew a person well before telling them about their illness, 62% reported that they attempted to correct their friends' negative views of those with mental illness. In a US study by Kleim et al. (2008) which measured how frequently 127 patients with schizophrenia would use withdrawal or secrecy, those who perceived higher levels of discrimination and devaluation showed higher scores in secrecy and withdrawal than those who perceived lower levels of discrimination and devaluation.

Rüsch et al. (2009) examined the relationship between cognitive coping with stigma (devaluing domains where people with mental illness stereotypically perform

poorly, ingroup comparisons and attributing negative outcomes to discrimination) and self-esteem, hopelessness, social performance and social distance from 'normal' majority group members among 85 people with mental illness (35% = bipolar disorder, 27% = schizophrenia, 26% = schizoaffective disorder, 12% = major depressive disorder) in the US. Stronger endorsement of all three coping strategies was related to greater social distance while proneness to ingroup comparisons (comparing themselves not so much to 'normals' but to other people who are also diagnosed with mental illness) was strongly related to poorer social performance. Devaluing work/education and blaming discrimination were significantly correlated with higher levels of hopelessness.

In a German study, Ilic et al. (2011) developed a questionnaire for assessing the management of stigma among people with mental illness based on a literature review and qualitative interviews with those affected. The questionnaire included 10 identity management strategies: selective temporal downward comparison, positive ingroup stereotyping, normalisation, community involvement, secrecy, overcompensation, selective disclosure, withdrawal, humour and information seeking. The authors assessed management strategies among 355 people with mental illness using said questionnaire (66% = depression, 42% = anxiety or panic disorder, 18% = psychosis, 10% = eating disorder; multiple answers permitted). The results revealed that selective temporal downward comparison (for instance, thinking that the situation of mentally ill people is much better than it used to be), which is a psychological strategy rather than a behavioural strategy, was the most frequently employed strategy, followed by selective disclosure. Positive ingroup stereotypes, community involvement and humour were significantly associated with higher self-esteem, whereas being very secretive and being careful about when and to whom to reveal one's illness and trying to disprove existing stereotypes about people with mental illness through personal behaviour were significantly related to lower levels of self-esteem. Ow and Lee (2015) examined coping orientation towards stigma (secrecy, withdrawal and education) among 80 patients with schizophrenia in Singapore. Higher levels of perceived stigma were related to less endorsement of educating others about mental illness and higher levels of endorsements of secrecy and withdrawal; moreover, secrecy was negatively related to self-esteem. However, secrecy did not significantly predict self-esteem. The authors note that this is possibly because of inadequate sample size.

Among these studies, the most commonly assessed coping strategies were secrecy, withdrawal and education. The meanings of these strategies are more or less

consistent across the studies.

It is well known that many people with mental illness have concealed their condition or stopped themselves from doing something in order to avoid stigma. Prior research often regarded people with mental illness as having anticipated stigma if they answered that they had concealed their illness or they had stopped themselves from doing something.

Thornicroft et al. (2009) surveyed 732 people with schizophrenia in 27 countries (mainly European countries, with some from Asia or North or South America). The authors used the Discrimination and Stigma Scale (DISC-10) to ask respondents about their anticipation of discrimination (how much they have stopped themselves from doing something such as applying for work because of their psychiatric diagnosis; or have concealed their diagnosis). The results revealed that 72% of respondents had felt the need to conceal their diagnosis. In contrast, 69% had stopped themselves from applying for a job, training or education because of their psychiatric diagnosis; most of these respondents (52%) had not experienced discrimination in these fields (findings on discrimination experienced in the next sub-section). In the same way as this finding, 60% stopped themselves from looking for close relationships and yet 56% had no experience of discrimination in this area.

Üçok et al. (2013) assessed anticipation and experience of discrimination among 103 outpatients with schizophrenia in Turkey using DISC-10 (Thornicroft et al., 2009). The results revealed that 75% of their respondents had stopped themselves from applying for a job, training and/or education. In total, 72% of them felt the need to conceal their diagnosis. Those who felt the need to conceal their illness had a significantly shorter duration of illness, less severe symptoms, lower number of suicide attempts, higher current employment rate, and a higher rate of remission than those who did not. Conversely, respondents who stated that they had often stopped themselves from applying for a job/training/education had a significantly longer duration of illness, more severe symptoms, lower functionality, and a higher number of suicide attempts than those who did not. The authors also examined the relationship between anticipated and experienced stigma. Those who had never experienced discrimination significantly less frequently felt more of a need to conceal their diagnosis than those who had experienced discrimination; this suggests that experiencing discrimination may lead to anticipation of discrimination.

In a multi-site survey on anticipated discrimination (the extent to which respondents conceal their illness and limit their own involvement in important aspects of

life because of how others might respond to their mental health problems) and experienced discrimination among people with depression, involving participants from 35 countries (Lasalvia et al., 2013; n = 1,082; half from Europe, remainder from other areas including Asia, North and South America, Africa and Oceania), 71% stated that they had concealed their illness and those who concealed it reported higher experienced and anticipated discrimination than those who disclosed it (79% experienced discrimination in at least one aspect of their lives). The scale of anticipated and experienced stigma was DISC-12 (Brohan et al., 2013). In total, 37% stopped themselves from initiating close personal relationships, whereas 25% stopped themselves from applying for a job. Respondents who had greater anticipated discrimination also experienced most discrimination. However, half of those who anticipated discrimination in work and/or intimate relationships had not experienced discrimination in these areas.

In an Italian study, Lasalvia et al. (2014) used DISC-10 (Thornicroft et al., 2009) and examined the extent to which 97 patients with first-episode psychosis limited their own involvement in important aspects of everyday life including close personal relationships, work and education. Fifty-eight per cent of them felt the need to conceal their diagnosis and 37% avoided having close personal relationships. Respondents were also asked about their experience of discrimination (the most common areas of experienced discrimination were relationships with family members and friends). Those who reported higher levels of anticipated discrimination had higher levels of experienced discrimination and greater insight. Hansson, Stjernswärd and Svensson (2014) surveyed 156 psychiatric outpatients (46% with anxiety disorder or depression, 39% with psychosis, 12% with neuropsychiatric disorder and 4% with other diagnosis) with regard to experienced and anticipated discrimination in Sweden, using DISC-12 (Brohan et al., 2013). The results showed that 69% of them had concealed their illness and 54% had stopped themselves from having close personal relationships; in addition, over 40% had stopped themselves from applying for a job and/or from applying for education or training courses. However, whereas a considerable proportion of respondents stopped themselves from having close relationships, applying for a job and/or applying for education or training courses, the majority of these respondents reported no actual experience of discrimination in these areas. With regard to the correlation between anticipated discrimination and the demographic characteristics of respondents, younger people reported more anticipated discrimination than the older ones.

Overall, the studies mentioned in this sub-section are relatively similar in terms

of their methods and show that people with mental illness have managed stigma using various strategies, including concealing their illness, educating others, stopping themselves from doing something, withdrawing from social life, and so forth. However, many ways of managing stigma were related to negative elements such as lower levels of self-esteem and unemployment, although there are some strategies, such as community involvement and humour which were correlated with higher self-esteem. It is also notable that many of the respondents who stopped themselves from doing something in specific areas such as work and education never experienced stigma in these areas. On the other hand, however, some studies found that higher levels of anticipated stigma were associated with higher levels of experienced stigma, which suggests that experience of stigma might lead to anticipation of stigma.

3-1-3. Experience of stigma

Corrigan et al. (2003) examined respondents' belief that they have been discriminated against because of their specific conditions such as mental illness and economic circumstances. The sample consisted of 1,824 US citizens with serious mental illness such as schizophrenia, bipolar disorder, or major depression. The results revealed that 73% of them thought that they had been discriminated against because of psychiatric disability, which was the most common perceived reason for discrimination; in contrast, 52% believed that they had been discriminated against for their economic circumstances. Angermeyer et al. (2004) assessed anticipated and experienced stigma among 210 patients with schizophrenia or depression (findings on anticipated stigma in the sub-section 'Perception of stigma'). Experienced stigma meant concrete stigmatisation experiences such as being rejected by someone because of their illness. The most common experience of stigma among respondents was rejection by others, both for those with schizophrenia (60%) and those with depression (45%). People with schizophrenia reported more frequent experience of stigma than those with depression in all areas, and the differences were statistically significant in three areas (avoidance of contact, partnership and taking out insurance).

Baldwin and Marcus (2006) analysed data from the 1994-1995 National Health Interview Survey in the US for experience of job-related stigma among 1,139 workers (80% with mood disorder, 8% with psychotic disorder and 62% with anxiety disorder; some people were included in more than one diagnostic group). This study showed that 20% of these workers experienced job-related stigma such as being refused promotion

and being fired because of their health condition. People with psychotic disorders more often reported experience of stigma than those with mood disorder or those with anxiety disorder (29%, 21%, 22% respectively). In addition, people who reported experience of stigma were more likely to report functional limitations and comorbid physical disorders than those who did not have such experience. The authors also examined wage differentials between people with mental illness and those without it, and between mentally ill people who reported stigma experience and those who did not. Whilst there were no significant differences in adjusted wages between people with mental illness who reported no stigmatising experience and those without mental illness (functional limitations and other productivity-related characteristics were controlled for), there was a large and significant difference in adjusted wages between people with mental illness who reported stigma experience and those without mental illness. Indeed, the former received 31% less wages than the latter. This gap was largest when comparing the adjusted wage ratio for people without mental illness and for people with psychotic disorders who reported stigma experience (17%).

In a New Zealand study, where discrimination was self-defined among respondents with mental illness, rejection by friends and family because of their illness was the most commonly reported form of discrimination (59%; $n = 785$, diagnosis not shown; Peterson et al., 2006), followed by employment. Thirty-four per cent reported that they had been rejected in a job interview when their illness had been revealed to their potential employer and 31% stated that they had lost jobs, they had been rejected by their colleagues, or they had been treated differently by them. Another 34% stated that they had been discriminated against in mental health services. Most of these respondents felt that they had been treated in an inhumane way. Verhaeghe, Bracke and Bruynooghe (2008) surveyed 595 service users of day activity centres for people with psychological problems in Belgium (diagnosis not shown) with a scale developed from Link et al. (1997) and Fife and Wright (2000). The scale asked respondents about their experience of stigma, namely how they are treated by others since they have attended the centres (for instance, respondents were asked to what extent they agree with the statement ‘Since I come to the centre, some people treat me with less respect’). Respondents who experienced more stigma because of their attendance at the centre had lower levels of self-esteem than those who experienced less stigma when symptoms were controlled for.

Bahm and Forchuk (2009) analysed data from a survey on mental health and housing in Canada ($n = 203$; 63% with psychiatric disability alone, and 36% with

comorbid psychiatric and physical disability). The aim was to examine how frequently they faced stigma. Sixty-four per cent reported facing stigma related to psychiatric disability (diagnoses: schizophrenia = 37%, bipolar disorder = 22%, depression = 17%, anxiety disorder = 10%, personality disorder = 7%). Those with both physical and psychiatric disability showed significantly higher levels of perceived stigma than those with psychiatric disability alone. Stigma experience was significantly and negatively correlated with physical condition, emotional well-being and life satisfaction.

Alonso et al. (2008) analysed data from the World Mental Health Survey, which was carried out in 16 countries (half in Europe, others in South and North Americas, Asia, Middle East, Africa and Oceania). The sample in the survey represented community residents of each country ($n = 80,737$; overall response rate = 70%), and the authors analysed the responses of those with significant activity limitations and who had mood disorders and/or anxiety disorders in the 12 months prior to the interview in their study (14% of respondents had significant activity limitations, of whom 26% had mood disorders and/or anxiety disorders). Respondents were asked whether they had experienced embarrassment and discrimination because of their health problems in the 30 days prior to the survey. Overall, 22% of those with mood disorders and/or anxiety disorders experienced both embarrassment and discrimination (31% in developed countries and 20% in developing countries), with these being significantly more likely to occur among people with mood disorders and/or anxiety disorders than those without mental illness when age, sex and education were controlled for. People with both anxiety and mood disorders had significantly greater likelihood of experiencing both embarrassment and discrimination than those with anxiety or mood disorder alone. The prevalence of experienced embarrassment and discrimination varied from 5% in Shanghai, China (cf. 18% in Beijing), to 37% in the US.

Alonso et al. (2009) analysed data from the European Study of the Epidemiology of Mental Disorders project, which used national representative samples of Belgium, France, Germany, Italy, the Netherlands and Spain ($n = 8,796$; overall response rate = 61%). In this project, 815 people had a 12-month mental illness and significant disability, and the responses of these people were analysed in order to identify the correlates and impact of experienced embarrassment and discrimination among them (responses of those with mood disorders, anxiety disorders and alcohol dependence/abuse were analysed). Fifteen per cent experienced both embarrassment and discrimination within the 30 days prior to the survey, while overall differences in prevalence were not significant among

the six countries. Experienced embarrassment and discrimination were significantly correlated with low education, being married or living with someone, being unemployed and having more difficulties in social life.

Lundberg et al. (2009) surveyed 200 Swedish people suffering from mental illness (35% with psychotic disorders and 34% with affective disorders) to ascertain whether they had been treated differently, less competently or had been avoided because of their illness. In total, 46% of respondents felt that people around them were uncomfortable after their psychiatric admission and 35% had been avoided by people who knew about their history of psychiatric hospitalisation; in contrast, only 10% had been turned down for a job for which they had been qualified because of their illness. Respondents who reported higher scores of experienced stigma had significantly lower levels of psychosocial function, higher frequency of inpatient episodes, psychotic disorder diagnosis and being on disability benefits than those who reported lower scores of experienced stigma. Thornicroft et al. (2009) surveyed 732 people with schizophrenia in 27 countries using the Discrimination and Stigma Scale (DISC-10). Respondents were asked whether they have been discriminated against because of their diagnosis of mental illness. Negative discrimination was experienced by 47% of respondents in friend relationships, by 43% in family relationships, and by 29% when attempting to find and keep a job; positive discrimination was rare.

Świtaj et al. (2011) compared the experience of stigma among 153 patients with schizophrenia, 106 patients with depression and 85 patients with malignancies in Poland using the Consumer Experiences of Stigma Questionnaire (CESQ; Wahl, 1999a). This questionnaire mainly asks respondents about experienced stigma (for example, whether they have been shunned or avoided when it was revealed that they received psychiatric treatment). The scale also contains a few questions which seem to relate to the perception or management of stigma rather than actual experience (for instance, whether they have concealed their illness from others). The authors included all of the question items when examining respondents' experience of stigma. Among respondents, patients with schizophrenia reported significantly higher levels of experienced stigma than those with malignancies after controlling for patients' background characteristics such as gender, age, living situation and employment status. There were no significant differences in levels of experienced stigma between those with schizophrenia and those with depression, although the authors suggest that the samples may well have been too small to detect existing differences. Świtaj et al. (2012) also surveyed 442 patients with mental illness

(63% with psychotic disorders, 14% with affective disorders, 14% with other diagnosis, 9% with multiple diagnoses) in Poland using the CESQ (Wahl, 1999a). The authors found that reported experience of stigma in the daily life section had been relatively rare at 12-35%, except for experience of hearing others say unfavourable or offensive things about people receiving psychiatric treatment and their illness (43%). On the other hand, 28% reported that they had been discriminated against by employers and/or supervisors, followed by family members (24%). Chien, Yeung and Chan (2014) examined whether 311 outpatients with mood disorder (unipolar or bipolar, 68%) and with schizophrenia or other psychotic disorders in Hong Kong had been rejected or discriminated against after psychiatric hospitalisation, using a scale which was developed from scales by Link (1987) and Wright et al. (2000). The most common area where respondents were treated differently was friendships (31%), while 18% stated that they had lost a job because their superiors had found out that they had been in a psychiatric hospital.

Farrelly et al. (2014) revealed that in a survey of 202 mental health service users in the UK (diagnosis details are in the sub-section 'Perception of stigma'), 88% had experienced discrimination in at least one area among 21 areas including family relationships, employment, and intimate relationships, in the last 12 months due to a diagnosis of mental illness. This study used DISC-12 (Brohan et al., 2013). Approximately 60% had been avoided or shunned by people. Higher levels of severity in experienced discrimination were correlated with higher education, being of mixed ethnicity, and higher levels of anxiety and depression.

Most of the studies mentioned in this sub-section differed in terms of their scales. For instance, whilst some studies examined experience of discrimination, some other studies examined experience of avoidance. In this vein, we should be aware of what each study assessed when comparing the findings of all said studies. However, a review of these studies provides an overall sense of the experienced stigma among those affected. As these studies show, many people have experienced stigma including in friend or family relationships and employment. Rejection by others and discrimination in employment were common. The findings also suggest that, overall, those with psychotic disorders, including schizophrenia, are more likely to experience stigma than those with other psychiatric or physical disorders. However, it is unknown whether respondents with psychotic disorders experienced stigma because of severe symptoms (or symptomatic behaviour), and whether experience of stigma led to the exacerbation of symptoms, or if they are interrelated.

3-1-4. Longitudinal studies

Although the majority of quantitative studies on the perception, management and experience of stigma among people with mental illness are cross-sectional in their design, there are also some longitudinal studies. Markowitz (1998) conducted a follow-up study of 90 psychiatric outpatients and 520 members of self-help groups run by mental health service users in the US (diagnoses; 63% depression, 37% panic/anxiety disorder, 19% schizophrenia, 19% personality disorder, 19% post-traumatic stress disorder). The aim was to examine the relationships between anticipated or experienced stigma, psychological well-being and life satisfaction (follow-up rate = 57%; duration = 18 months). Anticipated stigma was measured using Link's (1987) Devaluation-Discrimination Scale, whilst experienced stigma was assessed by asking respondents whether they felt they had been discriminated against or stigmatised because of their diagnosis during the six months prior to the follow-up. The results showed that there was a considerable degree of stability in each of the dependent variables, including anticipated or experienced stigma, self-concept, and self-esteem, across the 18-month interval. Discriminatory experiences had fairly consistent adverse effects both on psychological well-being and life satisfaction in lagged models.

Perlick et al. (2001) followed in- and outpatients with bipolar disorder or schizoaffective disorder (manic type) for seven months in the US (n = 264 at baseline; follow-up rate = 80%). With regard to this study, particular attention should be paid to those who had higher levels of concern about stigma at baseline, which were measured by the extent of social withdrawal and of perceived public stigma against people with a history of psychiatric treatment using the Link's Devaluation-Discrimination Scale (1987). Indeed, these people had more impaired social functioning during interactions with people outside their family at follow-up, after symptom level, baseline functioning and sociodemographic covariates were controlled for. Stigma concerns at baseline were also significantly and positively correlated with psychological isolation and behavioural avoidance in a regression analysis.

Mueller et al. (2006) followed patients with severe mental illness for 12-15 months in Switzerland (n = 289 at baseline, 165 at follow-up; 61% with schizophrenia-spectrum disorders and 39% with affective disorders). They found that the mean values of perceived social support, perceived discrimination, experience of stigmatising or rejecting behaviour and coping orientations of withdrawal and secrecy did not change

significantly over time. However, in the group of people whose duration of illness was six years and less, social support predicted perceived stigmatisation, with those who felt more support at baseline showing lower levels of perceived stigma at follow-up. In this study, perceived or experienced stigmatisation and coping orientations were assessed using an abbreviated version of Link's Discrimination-Devaluation Scale (Link, 1987; Link et al., 1997). Link, Castille and Stuber (2008) examined perceived devaluation and discrimination using Link's (1987) Devaluation-Discrimination Scale in a one-year follow up study of 184 outpatients with serious mental illness (40% with schizophrenia, 32% with schizoaffective disorder, 19% with bipolar disorder and 7% with major depressive disorder) in the US (follow-up rate = 74%). The results showed that the higher the levels of perceived devaluation and discrimination at baseline, the lower the levels of self-esteem at 12-month follow-up even when levels of self-esteem and other characteristics at baseline were controlled for. Self-esteem was not a predictor of subsequent perceived stigma.

Rüsch et al. (2010) surveyed patients with mental illness in the US over six months (n = 85 at baseline and 75 at follow-up; 52% with schizophrenia or schizoaffective disorder, 36% with bipolar disorder and 12% with major depressive disorder). The results revealed that higher levels of endorsed shame-related beliefs regarding people with mental illness at baseline predicted higher levels of perceived legitimacy of discrimination (individual's perception that the lower status of their group in society is fair) at follow-up, when baseline levels of perceived legitimacy of discrimination, perceived stigma and depression were controlled for. This result was unrelated to diagnosis. In this study, endorsed shame-related beliefs regarding people with mental illness were assessed by asking the extent to which respondents regard mentally ill people as proud or shameful. In another American study by Lysaker et al. (2012), in which 110 outpatients with schizophrenia were assessed at three time points over one year, stereotype endorsement (respondents' agreement with negative stereotypes of mental illness) and discrimination experience (actual experience of discrimination) were stable over periods of 5-7 months, but not over 12 months. Furthermore, although there was a concurrent relationship between the constructs of stereotype endorsement and discrimination experience, they were not associated with one another over time; there was no evidence that previous levels of discrimination predicted later levels of stereotype endorsement. With regard to instruments, this study used the Internalized Stigma of Mental Illness Scale (Ritsher, Otilingam and Grajales, 2003) to assess stereotype

endorsement and discrimination experience.

Noyman-Veksler et al. (2013) examined the relationship between experienced stigma and four self-concept aspects (self-esteem level and stability, perception of the self as ill and self-concept clarity) in outpatients with schizophrenia-spectrum disorder twice, separated by a six-week interval, in Israel ($n = 131$ at baseline, 89 at follow-up). Experience of stigma was examined using a scale developed for assessing community violence and a modified version of Link et al.'s (1989) Devaluation-Discrimination Scale in order to ask respondents about their actual experience of stigma. The authors found that self-concept clarity (individual's perception that he/she has a clear sense of who he/she is) at baseline was the only predictor of stigma experience at follow-up; higher level of self-concept clarity at baseline was significantly related to less experience of stigma at follow-up.

Corker et al. (2013) examined the changes in frequency of experienced and anticipated stigma among people using special mental health services in England between 2008 and 2011 with DISC-10 (Thornicroft et al., 2009). They selected a random sample of those receiving care for ongoing mental health problems ($n = 537, 1,047, 979, 1,016$ in 2008, 2009, 2010, 2011 respectively; response rate = 6%, 7%, 8%, 11% in 2008, 2009, 2010, 2011). Respondents' diagnoses varied, and yet those with bipolar disorder or depression accounted for approximately 50% in each year, followed by those with schizophrenia at around 10%. The proportion of respondents who experienced discrimination in the previous 12 months significantly decreased across the whole 4-year period. The most frequently reported sources of discrimination were family, friends and social life contacts across all years. There were no significant changes in anticipated discrimination between 2008 and 2011. Moses (2014) assessed 81 adolescents hospitalised for mental illness, at discharge and six months later, in the US (67% with depressive disorder, 32% with anxiety disorder, 19% with mood disorder NOS and 47% with other conditions; 55% had comorbid conditions). The results showed that, overall, the proportion of the participants who experienced stigma had remained stable between the periods, with the exception of an increase of 15% in the proportion of the participants who stated that people had used the fact that they are in treatment to hurt their feelings (from 25% to 40%).

Among these longitudinal studies, the majority examined the relationships between perception or experience of stigma and other variables such as self-esteem and coping strategies. Most of the studies used Link's scale in assessing perceived or

experienced stigma, and yet they used different variables in examining relationships with perceived or experienced stigma. The findings are generally consistent in that perceived or experienced stigma can have a negative influence, such as low self-esteem and psychological isolation, on those with mental illness over time. With respect to the changes in frequency of anticipated or experienced stigma, although two studies have focused on this (Corker et al., 2013; Moses, 2014), it is difficult to understand a general trend in the frequency changes of perceived or experienced stigma among people with mental illness from the findings of these studies, given that one of them received low response rates and another focused on adolescents in a specific area of the US.

The follow-up periods of the longitudinal studies in this sub-section are relatively short at five months to three years (average 14 months). As such, it is unclear how the perception, management and experience of stigma may change or how these may affect individuals over a longer period.

Across both the cross-sectional and longitudinal studies, except for those where respondents' diagnoses are not shown, people with schizophrenia or psychotic disorders were most frequently included, followed by those with depression or bipolar disorder. On the other hand, people with eating disorders, post-traumatic stress disorder or dissociative disorder were rarely included in these studies, thus making it difficult to understand their perception, management and experience of stigma. Although the number of studies examining differences in the perception, management and experience of stigma between specific diagnoses is limited, generally speaking, the findings of these studies show that (1) those with psychotic disorders or schizophrenia reported higher levels of experienced stigma than those with a different diagnosis and (2) those with more severe symptoms perceived or experienced stigma or limited their own involvement in important aspects of everyday life significantly more frequently than those with less severe symptoms because of their diagnosis.

3-2. Qualitative studies

Qualitative studies have described, in detail, how people with mental illness perceive, manage and experience stigma. Dinos et al. (2004) conducted interviews with 46 people with different psychiatric diagnoses (schizophrenia = 13, bipolar affective disorder = 5, dual diagnosis of psychosis and drug dependence = 13, major depression = 5, mixed anxiety and depression = 6, eating disorder = 2, personality disorder = 2) in the UK. The participants were asked to talk about the impact of their illness on their work and private

life. As for stigma related mental illness, most of the participants (89%) felt stigma. Their feeling of stigma was often related to the psychiatric diagnosis, which was particularly true for those with psychotic illness, although the participants with depression and/or anxiety disorder tended to be relieved when having received their diagnosis. Most of the participants (87%) mentioned the disclosure of their illness, which included their concern about how to manage information regarding their illness. Some of them concealed it or disclosed an edited version of their diagnosis which they regarded as less stigmatising. A number of other respondents found representations of mental illness in the media uncomfortable and stigmatising. Over half (63%) experienced overt stigma, which included verbal or physical abuse, loss of contact, patronising attitudes and discrimination. Whilst those with psychotic illness more often reported physical abuse, loss of contact and discrimination, those with non-psychotic illness tended to report less severe forms of stigma and were more likely to report experience of being patronised.

González-Torres et al. (2007) examined experience of stigma using focus groups with 18 patients suffering from schizophrenia and 26 family members of those with schizophrenia in Spain. Participants were asked to talk freely about specific topics such as work and family. The results revealed that almost all of the patients and family members had experienced stigma. Most of the participants reported having experienced a lack of understanding of mental illness, with people regarding mentally ill patients as 'lazy' or 'overdramatic'. They had also been treated as dangerous, unpredictable or 'psychopaths' or as someone who could not do anything on their own and was over-protected. Furthermore, the participants mentioned various situations where they met opposition to having children, with one of them having taken permanent contraceptive measures.

Jenkins and Carpenter-Song (2008; 2009) studied subjective experience of schizophrenia, including stigma, using semi-structured, open-ended interviewing, naturalistic observation and standardised questionnaires in the US (n = 90 outpatients with schizophrenia or schizoaffective disorder). Nearly all their participants (96%) reported that they were aware of stigma across a variety of social settings on a daily basis. Although these participants had recovered relative to their previous state of illness, they must have faced social stigma daily. The majority of them tried to avoid being stigmatised by concealing their diagnosis or medication or not contacting others, although they distinguished contexts in which they felt free and safe to disclose their illness. It was common for the participants to conceal their illness in the workplace, mostly because they

feared possible certain negative consequences of disclosing it. One of the other strategies used to avoid stigma was attempting to pass for 'normal'; many participants expressed their desire to return to normalcy or to pass publicly for 'normal'.

Rose et al. (2011) examined experience of stigma among people with schizophrenia in the International Discrimination and Stigma Outcomes (INDIGO) project, using DISC-10, which contains both quantitative and qualitative components (Thornicroft et al., 2009). The project included 732 respondents in 27 countries. Of all these data, the authors analysed five qualitative transcripts from each of the 15 sites in order to understand concrete examples of stigma experience amongst the participants (Brazil, Bulgaria, Cyprus, England, Finland, France, Greece, Italy, Lithuania, Malaysia, Romania, Slovakia, Slovenia, Turkey and the USA; there were no significant differences between participants included in the analysis and the rest of the sample in terms of socio-demographic characteristics, except for main type of mental health care). The results showed that there were few cross-cultural differences in the concrete experience of stigma among the countries. Being shunned, of which sub-themes included being abused and lack of understanding, was the most common theme. In a study on experience of discrimination among people with mental illness in Ireland (Lakeman et al., 2012), which included 30 participants who varied in their diagnosis (bipolar affective disorder = 9, major depression = 8, anxiety disorders, borderline personality disorder, schizophrenia = 1 respectively), most of the participants experienced discrimination, including in employment, personal relationships, health care and business and finance (interview questions not shown). Half of them had a fear of disclosing their illness and experience of discrimination led to moderate or significant distress.

Bonnington and Rose (2014) examined experience of stigma and discrimination among 46 people with bipolar disorder or borderline personality disorder by conducting interviews with topic guides. The key topics explored included participants' understanding of stigma and discrimination and whether they felt they had experienced stigma or discrimination in relation to their mental health (diagnosis). All participants anticipated, and most of them experienced stigma in various areas including health care, intimate or family relationships, workplace relationships, neighbourhood and education. They felt unjustifiably labelled pathological because of their diagnosis or unjustifiably normalised (people regarded them as not ill but as morally transgressive); they also received stereotypical judgements related to their diagnosis and general mental illness. These made them feel powerless in developing subjective interpretations of their

problems and efficacious strategies to manage them. As for differences between perception and experience of stigma amongst people with bipolar disorder and those amongst people with borderline personality disorder, the former often anticipated and experienced stigma in employment, whilst the latter did so mostly in healthcare, although both anticipated and experienced stigma within these two contexts.

Qualitative studies have also shown that the perception, management and experience of stigma can vary across cultures. In their mixed-methods study, Weiss et al. (2001) compared the perception and experience of stigma between patients with depression in Bangalore and London (n = 80 in Bangalore, 47 in London³⁷; interview questions not shown); the results revealed cultural differences in terms of the perception and experience of stigma between Indian and British participants. Narratives of the participants in Bangalore focused upon concerns about respectability and status in society, as people rely upon their social standing and social esteem is highly valued in India. The participants also worried that their own or their relatives' marriage arrangements, which are regarded as important in Indian society, would fail if people knew that they suffered from depression. In the British sample, on the other hand, their accounts often focused upon intolerance of weakness and concerns about being a burden to others. They thought that weakness was not tolerated in British society and had the fear that it would show weakness if they disclosed depression.

In an American study, Interian et al. (2007) revealed that, through a focus group study where participants were asked about 11 topics related to issues of antidepressant adherence and culture (n = 30, Latino outpatients with depression receiving antidepressants), over 70% of the participants felt that stigma was attached to taking such medication. Participants seemed to suffer from negative attributes which they associated with antidepressant medication, including 'severe' illness, weakness and inability to deal with problems. They suffered mostly when receiving the diagnosis for the first time and when starting antidepressant treatment. The authors note that drug addiction has an independent and very negative connotation in Latino culture, which possibly led to the participants' typical concerns that people may regard them as being addicted to medication. The authors also point out that the participants identified Latinos as hardworking and ready to fight against problems. Indeed, this often contradicted negative

³⁷ The authors analysed narrative accounts from the responses of participants whose stigma scores, which were measured with a questionnaire, were in the upper quartile for the qualitative part of this study. The number of narrative accounts analysed is not shown.

attributes of taking antidepressants and therefore the participants needed to overcome an additional barrier to treatment.

Alvidrez, Snowden and Kaiser (2008) explored stigma concerns, experience and coping strategies amongst 34 Black people with mental illness in the US (diagnoses: depression = 22, schizophrenia and related disorders = 14, anxiety disorder = 12, bipolar disorder = 8, Axis II = 5). Participants were asked whether they received any negative reactions from people for having mental health treatment and how they dealt with those reactions from others. The results showed that 68% of participants stated that mental illness and seeking mental health treatment were viewed negatively in society. Thirty-five per cent of them thought that any mental health problem was regarded as crazy, whilst 21% thought that seeking help would damage family reputation. Moreover, 41% of them reported that they had encountered negative or judgemental reactions from others for seeking psychiatric treatment, including being regarded as different and being verbally abused. Furthermore, 21% stated that they had been rejected or avoided by others because of their history of psychiatric treatment, whereas 15% chose to end friendships or become more distant from friends or family to avoid stigma. Some (26%) talked about their awareness of how mental illness is viewed in Black culture; for them, having mental health problems was incompatible with Black values of strength, resilience and religious faith. With respect to coping strategies, although 32% used selective disclosure, most participants dealt with negative reactions from others by thinking that their health and well-being were more important than the opinions and reactions of others (94%) and by seeking social support (76%).

Michalak et al. (2011) conducted individual and focus group interviews with 32 people with bipolar disorder in Canada in order to explore their stigma experience. Participants were asked whether they experienced stigma as a result of having bipolar disorder, whether their diagnosis of bipolar disorder had an impact on their thoughts about themselves, and whether they felt that there are barriers in the healthcare system affecting their ability to stay well. The results showed that all of the participants anticipated or experienced stigma related to their illness. Culture was one of the factors which affected their perception of stigma; those who identified themselves with a particular ethnic group, including British, Asian or Indo-Canadian, felt increased stigma because of the culture of their ethnic group. In the same way as people with a different psychiatric diagnosis, it was also common for the participants in this study to conceal their illness, except for people who were, they thought, safe to disclose to or in situations where disclosing was necessary

or advantageous.

Shefer et al. (2012) examined the influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities (South Asian, black African and black Caribbean) in the UK. They achieved this by analysing data from ten focus groups, five with mental health service users and five with lay persons (diagnosis not shown). Most of the participants (both service users and lay persons) perceived more stigma in their ethnic communities than in the British community as a whole. There was also agreement across the groups that there were strong pressures to maintain secrecy about mental illness in their communities, as this kind of news could harm a family's reputation and the marriage prospects of siblings. In some cases, this led to delays in seeking help or concealing their illness from their immediate family members.

Identical to the findings of quantitative studies, those of the aforementioned qualitative studies showed that stigma has been found to be endemic both in the contexts of perception and experience; moreover, those with mental illness use their own methods to manage stigma. Qualitative studies, however, found concrete examples of stigma experience to which quantitative studies have paid little focus, such as lack of understanding about mental illness. Another novelty of the findings of qualitative studies is that they showed that the perception, management and experience of stigma can differ between cultures. When interpreting the findings, however, we should be aware that most of these studies did not define stigma or discrimination clearly, which signifies that the meanings of these concepts depend on participants' interpretation in the aforementioned studies. With regard to types of mental illness, people with schizophrenia were most commonly included in these studies, as was the case in quantitative studies.

Although the studies on experienced stigma mentioned in this chapter provide various findings, most of them focus on the experience itself, and do not examine it in relation to the perception and management of stigma, which can be the background of the experience. As we saw in the Preface, this is the reason for the subsidiary aim of the present study, which is to describe not only experienced stigma but also the perception and management of stigma in detail. By doing this, it will be possible to obtain a more comprehensive understanding of stigma.

3-3. Studies on the perception, management and experience of stigma among people with mental illness in Japan

As opposed to Europe and the US, there have been few studies on the perception,

management and experience of stigma among people with mental illness in Japan.

In a questionnaire survey, Shiraishi (1994) found that 62% of the participants (n = 907, psychiatric inpatients and outpatients) had had uncomfortable experiences in their social life. Suzuki (2009) examined experience of stigma using DISC-10 (Thornicroft et al., 2009) with 25 outpatients suffering from schizophrenia; the results revealed that 64% of participants stated that they had been treated differently to others in a negative sense because of their diagnosis, at least in one area of life. The areas in which they had been most commonly treated negatively were family and making friends (52% respectively).

Some qualitative studies using a small number of sample have shown how people with mental illness perceive, manage and experience stigma, although their primary focus is not stigma-related.

Kitamura (2004) conducted unstructured interviews using the life history method with two men suffering from schizophrenia. These people had been ill for more than 20 years and lived in the community at the time of interview. For both of them, having schizophrenia was one of the important ‘changing points’ in their lives, and it took them a long time to accept that they were mentally ill. One of them suffered from cruel treatment by the psychiatric staff in hospital when he was staying there and felt that his ‘former self’ (i.e. the person he used to be before hospitalisation) had disappeared. Another interviewee thought that schizophrenia deprived those affected of the things which people usually have, such as family and work.

Conducting interviews with six outpatients suffering from schizophrenia, Fujimoto and Kawaguchi (2008) described the process whereby the participants became aware of their diagnosis and dealt with the fact that they had been diagnosed with schizophrenia. Most of them became aware of their diagnosis when they saw their patient record. Some of them became anxious or did not understand why they had been diagnosed as such when they became aware of their diagnosis. Others became angry, and were unable to understand why they had such an illness, or lost confidence in themselves. After they became aware of their diagnosis, whilst some of them tried to accept themselves as they were, as someone with schizophrenia, others thought that they wanted to be as they had been before they became ill. Although some participants disclosed their diagnosis to others and felt easier to do that with the term ‘Tôgô Shitchô Shô’, which is a new term for schizophrenia which has been used since 2002³⁸, others concealed their diagnosis.

³⁸ The Japanese Society of Psychiatry and Neurology had discussed renaming the old term since 1993, as the old term was not conceptually appropriate and gave a negative impression to people.

Sekine (2011) conducted seven interviews with people with mental illness who had been in hospital and currently lived in the community in order to clarify how people with mental illness adjust to lives in the community. Most of the interview participants suffered from schizophrenia, with one participant with bipolar disorder. The author classified their processes of social adjustment into four phases. Of these phases, the most important phase for the present study is the third one, as the third phase is related to the perception and management of stigma. In the third phase, the interview participants feared that neighbours might suspect that they were psychiatric patients and think of them as ‘mad’, and the participants tried to be a ‘normal adult’ because of the fear.

As can be seen from the review in this section, in Japan, although there are some studies including stigma-related themes, the number of studies which focus on the perception, management and experience of stigma among people with mental illness is limited. Because of this, it is difficult to understand how they feel, deal with and experience stigma in Japan.

3-4. Summary

This chapter reviewed the findings of studies on the perception, management and experience of stigma among those with mental illness, mainly in European countries and the US.

A large body of cross-sectional research showed that it was quite common for people with mental illness to perceive, manage or experience stigma, irrespective of countries, although the degree of frequency varied between countries. Some studies also found that the perception, management or experience of stigma was related to higher levels of symptoms and/or lower levels of self-esteem, quality of life, life satisfaction, and so forth. Many people who stopped themselves from doing something in specific areas such as work and education never experienced stigma in these areas. However, some studies found that higher levels of anticipated stigma were associated with higher levels of experienced stigma, which suggests that experience of stigma might lead to anticipation of stigma.

The findings of longitudinal studies were generally consistent with those of cross-sectional studies in that perceived or experienced stigma could have a negative influence, such as low self-esteem and psychological isolation, on those with mental

The families of people with mental illness also asked for the old term to be renamed, as they regarded it as stigmatising (Iwadata et al 1996; Sato 2006).

illness over time. Methodologically, for both cross-sectional and longitudinal studies, it should be noted that, whilst there are studies which are similar or the same in their scales, there also are studies which differ in this regard.

Whilst qualitative studies also showed that stigma had been found to be endemic both in the contexts of the perception and experience, and those with mental illness used their own ways to manage stigma, one of the novelties of the findings is that they showed cultural influence on the perception, management and experience of stigma. With respect to types of mental illness, for both quantitative and qualitative studies, schizophrenia was most commonly examined.

As opposed to Europe and the US, in Japan, there is a dearth of research exploring the perception, management and experience of stigma among people with mental illness.

In the next chapter, we will see how the present study deals with the objectives shown in the Preface: (1) to clarify the time trends in social attitudes to mental illness in Japan and (2) to clarify how people with mental illness perceive, manage and experience negative stigma in Japan, with a sub-focus on the changes over time.

CHAPTER FOUR: METHODS

This chapter presents the methods employed by the present study in order to clarify (1) the time trends in social attitudes towards mental illness in Japan and (2) how people with mental illness perceive, manage and experience negative stigma in Japan, with a sub-focus on the changes over time.

4-1. Research design

The present study employed document analysis and interviews. For document analysis, newspaper articles were used to examine the changes in social attitudes towards mental illness and magazine articles were used to examine concrete examples of how people with mental illness perceive, manage and experience stigma and their changes over time. Interviews with people suffering from mental illness were conducted in order to gain a deeper understanding of their perception, management and experience of stigma.

4-2. Analysis of newspaper articles

4-2-1. Objective and materials

Newspaper articles were analysed to clarify the changes in social attitudes towards mental illness over time. Analysis of newspaper articles is suitable for examining specific views in society, such as views on mental illness, as the press records the most influential political and social views expressed at any particular time and is one of the most important public source materials (Tosh, 2002, pp. 63-64). Furthermore, and rather important, is the fact that analysis of newspaper articles makes it possible to look at changes in people's views on mental illness in Japan over time, given that there have been no longitudinal studies on social attitudes towards mental illness in this country.

In the present study, four high-circulation national newspapers were selected for analysis: the Yomiuri newspaper, the Asahi newspaper, the Mainichi newspaper and the Nikkei Newspaper. These newspapers have been selected not only because they have the highest circulation, but also because they are different in terms of their political thoughts and their focus; Yomiuri is right-leaning, while Asahi and Mainichi are left-leaning and the Nikkei focusses upon news related to the economy.

4-2-2. Method of analysis

Articles were analysed using the method of qualitative content analysis. Qualitative

content analysis is employed in order to systematically describe the meaning of material (Krippendorff, 2004). One of the major characteristics of this method lies in its focus upon selected aspects of the material to be analysed; indeed, its main strength is that it is possible to analyse and describe particular characteristics of large amounts of qualitative data, although this method does not provide an in-depth understanding of the material (Schreier, 2012). Procedures of qualitative content analysis include building a coding frame, evaluating and modifying it, and applying it to all the material to be analysed (Neuendorf, 2002; Schreier, 2012). This method is suitable for the present study, as it was necessary to analyse many articles and the objective of analysis was to clarify specific aspects of articles (how mental illness or people with it were reported). The objective of analysis was to describe views on mental illness in Japan and not to obtain an in-depth understanding of this issue.

4-2-3. Search strategy

Newspaper articles published in 1987, 1996, 2005 and 2014 were analysed. 1987 was the earliest year for which a full-text search was available for all the four newspapers through their databases (only keyword search was available for the articles published before 1987 for the Yomiuri Newspaper). The newspaper databases were searched using the following terms: mental illness OR mental disorder OR neurasthenia OR pervert OR psychiatric OR manic OR schizophrenia OR bipolar disorder OR depression OR PTSD OR anxiety disorder OR panic disorder OR eating disorder OR obsessive compulsive disorder OR personality disorder.

4-2-4. Sample procedure

The present study employed constructed week sampling, which is a stratified random sampling technique popular in media studies. This sampling involves identifying all Mondays before randomly selecting one particular Monday, and repeating the same procedure for all the remaining days of the week to construct a week. Constructed week sampling is superior to simple random sampling and consecutive day sampling because it more adequately represents the population (Riffe et al., 1993; Luke, Caburnay and Cohen, 2011). Lacy et al. (2001) showed that sampling a minimum of two constructed weeks was the most efficient way to accurately estimate one-year of one newspaper's coverage. The present study constructed four weeks per year for each newspaper. When no article was available for a specific day of the week, a random article was selected from

an adjacent day of the week (n=5).

4-2-5. Inclusion/exclusion criteria

Articles fulfilled the inclusion criteria if they focussed upon mental illness, those who were receiving psychiatric treatment, those experiencing mental illness, the services they received, or mental health related Laws and regulations. Among the materials excluded from the study were obituaries, articles about art, sports, travel or things that happened outside Japan and notices of lectures, social gatherings and so forth. Furthermore, as this study did not include epilepsy, substance abuse, dementia, intellectual disability and developmental disorders in the definition of mental illness, articles that only included topics related to one of these disorders were also excluded.

4-2-6. Coding frame

A coding frame was developed based upon existing analysis of newspaper coverage of mental illness in the UK and the US (Corrigan et al., 2005; Goulden et al., 2011). The coding frame used in Corrigan et al.'s study drew on the findings of previous research and input from advocates in the mental health field. Whilst their codes seemed useful, some of them were too detailed, and thus the codes in Goulden et al.'s study were also referred to for increased simplicity. The codes in the study by Goulden et al. were developed from Corrigan et al.'s study and Wahl et al.'s (2002) longitudinal study. These UK and US studies were employed to develop a coding frame, as there was no Japanese study which could be referred to for a coding frame; although there were several Japanese studies analysing newspaper articles about mental illness, none of them used qualitative content analysis.

Story themes derived from the two studies were piloted with a 7% random sample in each year (1987, 1996, 2005 and 2014). Each article was coded for its primary theme. The initial coding frame was developed by accepting, adjusting or rejecting the themes or creating and adding new themes. This coding frame was checked with a 10% random sample and was revised. A reliability check was performed on another 7% random sample, working with a Japanese Master's student who was trained to code articles. We coded these articles independently, which resulted in a kappa score of 0.69. This signifies substantial agreement between raters.

Table 1 shows story themes in the existing studies as well as those included and newly created in the present study. The 'Mental illness as stress-related illness' category

was created just for the present study. Moreover, articles that focussed upon the fact that a court, the Labour Standards Inspection Office or medical professionals judged that an individual's mental illness had been caused by job stress were classified into the theme 'stress caused by work'. In contrast, when it was judged that an individual's mental illness had been caused by other forms of stress, the articles were classified into the theme 'stress caused by other reasons'.

The story themes were classified into four categories ('Dangerousness', 'Understanding mental illness', 'Mental illness as stress-related illness' and 'Services, institutions and Laws'); in addition, the four categories were divided into two groups according to the characteristics of each category: 'Harm to others/themselves' and 'Understanding of/concern for mental illness'. In this grouping, the category 'Dangerousness' was classified as the first group and other categories were classified as the second group.

Articles were also coded for diagnoses mentioned, in order to examine the variation of diagnoses and to assess how different the primary story themes are between diagnoses. The present study compared articles about schizophrenia to those concerning depression. This is firstly because prior studies have found that the general public in Japan showed significantly different attitudes between these diagnoses and therefore newspaper coverage may also describe these diagnoses differently. The second reason is that looking at how these diagnoses are portrayed in the media may help us to understand the background of the perception, management and experience of stigma among the interview participants in the present study; as we will see in the sub-section pertaining to interview participants in this Chapter, all the participants had a diagnosis of either schizophrenia or depression.

4-2-7. Statistical analysis

Articles were coded using SPSS version 22.0 and analysed in Stata version 14. The number and proportion of article themes are presented by year, diagnosis and newspaper. Mantel-Haenszel chi-squared tests were undertaken in order to assess the significance of a change across four time points. A hypothesis was operationalised as a significant ($p < 0.05$) reduction in the proportion of articles with 'Harm to others/themselves' themes and a significant increase in the proportion of articles with 'Understanding of/concern for mental illness' theme. Fisher's exact test or Pearson's chi-squared (when appropriate) was also used in order to (1) compare differences in the proportion of articles with

‘dangerousness’ themes between diagnoses and between newspapers at each time point and (2) to compare differences in the proportion of articles with a ‘suicide and self-injury’ theme and differences in the proportion of articles with a ‘violent crime’ theme between diagnoses at each time point. A Holm-Bonferroni adjustment for multiple testing was applied to the P-values of the tests.

Table 1. Story themes in the previous studies and present study

Corrigan et al., 2005	Goulden et al., 2011	Present study
Themes	Themes	Themes
Blame	Bad news	Articles about people who harmed others or themselves
Personal blame	Danger to others	Dangerousness
Parental failure	Suicide and self-injury	Violent crime
Genetic or biological cause	Victimisation and severe mistreatment	Nonviolent crime
Environmental cause	Strange, inept or burdensome	Suicide and self-injury
Dangerousness	Good news	Mental illness as legal defence
Danger to others	Understanding mental illness	Victimisation and severe mistreatment
Violent crime	Explaining: causes, treatments, prevalence and symptoms	Articles about understanding of / concern for mental illness
Nonviolent crime	Biological	Understanding mental illness
Suicidal or self-injurious behaviour	Psychosocial	Individuals and groups affected by mental illness
Mental illness as legal defence	Not specified	Research advances
Legal competence	Individuals and groups affected by mental illness	Explaining: cause
Criminal victimisation	Services and advocacy	Genetic or biological
Drug and alcohol abuse	Mental health service inadequacies and improvements	Environmental
Treatment and recovery	Stigma, discrimination and public education	Others

Table 1. Continued.

Corrigan et al., 2005	Goulden et al., 2011	Present study
Themes	Themes	Themes
Research advances		Explaining: treatments
Biological treatments		Biological
Psychosocial treatments		Psychosocial
Recovery as an outcome		Others
		Explaining: prevalence and symptoms
Advocacy actions and concerns		Mental illness as stress-related illness
Poor-quality and concerns		Stress caused by work
Shortage of resources		Stress caused by other reasons
Homelessness		Services, institutions and Laws
Housing issues		Inadequacies
Insurance parity		Improvements
		Introduction of services or institutions

4-3. Analysis of magazine articles

4-3-1. Objectives and materials

Magazine articles were analysed to clarify concrete examples of the perception, management and experience of stigma among people with mental illness, their changes over time, and how the readers narrated their stories. Analysis included three magazines: 'Zenkaren' (short for 'the National Federation of Families of the Mentally Ill in Japan'), 'Minna net' ('Everyone's Network') and 'Kokoro no genki' ('Mental Health'). The first two magazines mainly provide information which can be useful for both people with mental illness and their families (for instance, introduction of findings of recent research on schizophrenia) while the last magazine mainly offers information for mental illness sufferers (for example, information about new types of treatment for mental illness and newly developed social services for them). These magazines were chosen for analysis since many of their back numbers included articles concerning personal experiences of people with mental illness and it is possible to examine changes in the content over time. The present study included the following two elements in a definition of 'perceived stigma', according to the findings of a review of studies on stigma by LaBel (2008, p. 414):

- a) what an individual thinks most people believe about the stigmatised group in general and
- b) how each individual believes society views him/her personally because he/she is a member of the stigmatised group.

The present study defined management of stigma as 'strategies for coping with stigma'. As for 'experienced stigma', the present study defined it, based upon the conceptualisation and definition of stigma put forth by Thornicroft (2006) and Thornicroft et al. (2007; 2009), as 'being told prejudicial things or being treated differently to others in a negative way because of mental illness diagnosis or being told things which are based upon ignorance about mental illness or being treated in the manner which is based upon ignorance about or prejudice against mental illness'.

4-3-2. Inclusion/exclusion criteria

The three magazines were hand-searched, as they have not been digitised. 'Zenkaren' was first issued in 1965 and discontinued in 2007. While this is a magazine for families of mentally ill people, it offers many articles written by people with mental illness

themselves. 'Minna net' and 'Kokolo no genki' have been published since 2007. The duration of the search for 'Zen karen' spanned from 1965 to 2007 and that for 'Minna net' and 'Kokolo no genki' was from 2007 and 2013. Articles fulfilled the inclusion criteria if (1) the main focus was upon the perception, management and/or experience of stigma among people with mental illness, or (2) they contained a story about perceived, experienced and/or management of stigma among people with mental illness and (3) they provided a concrete explanation about the perception, experience and/or management. Articles were excluded if they lacked concrete explanations. For instance, articles in which a person with mental illness states 'I was discriminated against' but gives no explanation about it were not included, as it is unclear what treatment he/she regarded as discrimination.

4-3-3. Method of analysis

Articles were analysed using the method of qualitative content analysis, as in the analysis of newspaper articles. This method was considered suitable for analysing magazine articles, since the objective of analysis was to clarify specific aspects of articles: (1) the perception, management and experience of stigma among people with mental illness and (2) how they narrate them.

There was no Japanese study which analysed representation of the perception, experience and management of stigma among people with mental illness in written material such as books, newspaper or magazine articles using a systematic method. This means that there was no coding frame to which could be referred in the present study. Therefore, a coding frame was developed based upon the content of randomly selected articles. With respect to the procedure of building a coding frame, I followed the method put forth by Schreier (2012).

First, 15% of all stories which had been selected randomly were read and coded for the theme of each story. After the coding, codes were grouped according to similarity. Each group was then placed under one of three main categories ('Perception', 'Management' and 'Experience'). When a group could not be classified into these three main categories, an overarching code, which is the name of a main category, was given to this group. Subcategories consisted of variations of the main category to which they belong. In order to adhere to Schreier's suggestion (2012), only the codes which appeared more than twice were defined as an independent subcategory, whilst those that appeared only once were classified as the subcategory 'Others'. In addition to story themes, the

present study looked at how stories were told, creating categories for ‘elements’. When an article contained both a story about stigma and a story which was not related to stigma, I coded the story about stigma for its theme and looked at the whole article to clarify in what context the story was told (elements). I looked at, for instance, whether a story about positive experience followed the story about stigma. Finally, for story themes, a hierarchical structure around main categories and subcategories was created. For elements, four main categories were created. A pilot analysis with another randomly selected 15% of stories was conducted using this structure, namely the coding frame, and the categories for elements. After this, the frame and categories for elements were revised and a blind intercoding between the author and a Japanese Master’s student who was trained to perform the analysis was conducted using the revised frame and categories for elements on a randomly selected 10% of articles as a reliability test. This resulted in a kappa statistic of 0.89 for the frame and 0.93 for the elements, which indicates almost perfect agreement between raters. The final coding frame and categories for elements will be shown in Chapter Six with the results of analysis.

4-4. Interviews

4-4-1. Objective and participants

The objective of the interview study was to obtain a deeper understanding of the perception, management and experience of stigma among people with mental illness in Japan. A deeper understanding means to comprehend the relationships between the three elements and what lies behind each element.

The first recruitment process was conducted by sending letters to the directors of community activity support centres for psychiatric patients in Tokyo. Community activity support centres offer services, such as helping people with disabilities/disorders to find a job, or teaching them how to use a computer. However, most of the directors contacted refused to let their service users take part in the study, the most common reason for their refusal being that they would like to protect their service users’ privacy³⁹.

³⁹ The directors’ overprotective attitudes may be one of the characteristics of mental health professionals in Japan. Kawamura, who is a psychiatrist, points out that it is difficult for people with mental illness to act independently under the influence of paternalism of the medical system in Japan (Fujiwara, 2007). I have visited several community activity support centres in Tokyo, and it seemed to me that the service users were required to follow the programmes offered, rather than to act voluntarily. In this sense, the community activity support centre where I recruited the first six participants is an exception. This centre is run based on the club house system, which originated in the United States. The service users are asked to think what they want to do at the centre themselves and the staff pay great respect to the service users’ voluntary thoughts and acts. This may be one of

However, a director of a community activity support centre whom I contacted through my acquaintances, invited me to their facility to give a detailed explanation of the study. After I explained about the study at their centre, the director and service users discussed participation, and six service users wished to take part. The first interviews were conducted with these six service users face-to-face, according to their preference.

All of these participants suffered from schizophrenia and most of them were receiving job training at the centre. After analysing the data from these six interviews, it became clear that it would be necessary to conduct interviews with people suffering from depression, since none of the six participants had experienced situations where people regarded them not as ill but as lazy, which seemed a common experience of stigma for people with depression in magazine article analysis. It also seemed necessary to better understand the experience of people with schizophrenia at work or when applying for a job, as only one of the interview participants had work, which was a sheltered job, at the time of interview. It was felt that it was impossible to obtain sufficient data regarding the perception, management and experience of stigma in people with schizophrenia who were currently working. Since four of the participants had experience of working after they became ill, it was possible to obtain data about this experience, and yet there was a possibility that the experiences of people who are currently working would differ from the experiences of these participants, as two of them had this experience more than ten years ago.

A second recruitment process was therefore conducted by contacting a psychiatrist and a psychotherapist (both were working for psychiatric hospitals in Tokyo at the time of recruitment). The aim was to recruit people with depression and people with schizophrenia who currently had a job. I did not consider another recruitment process through directors of community activity support centres, firstly because it was difficult to recruit participants in this way and, secondly, because it is almost impossible to recruit people who are in work from these facilities, as they are essentially providing service users with training for finding work.

During the second recruitment process, 14 people wished to participate in the study. Interviews with these people were also conducted face-to-face, according to their preference. As will be shown in the section of ‘method of analysis’ below, I did not conduct further recruitment, since I reached the conclusion, after having analysed all of

the reasons why the director of this centre allowed me to recruit participants there.

the data, that further data would not be necessary for the present study.

The total population of the participants was equally divided into men ($n = 10$) and women ($n = 10$), of whom 12 had a diagnosis of schizophrenia, while 8 people were diagnosed with depression. They were all well-functioning psychiatric outpatients, with stable symptoms. Most participants were receiving only drug treatment; just one participant was receiving both drug treatment and counselling. The average duration of treatment was 14 years (range from 1-40 years). In total, 13 participants experienced psychiatric hospitalisation, and the average duration of stay was eight months (range from 1-13 months). Table 2 shows the demographic, diagnostic and employment profile of the participants.

All the participants, including the first six participants, received both an oral and written explanation about the study before interview (see Appendix 1) and only those who wished to participate voluntarily had an interview. The participants gave a written consent form before interviews (see Appendices 2 and 3). People having any problems with participation were excluded according to the judgement of the director of the centre or mental health professionals⁴⁰.

4-4-2. Procedures

Prior to interview, the participants were asked to complete a questionnaire, which included questions about their age, gender, diagnosis, history of psychiatric treatment and so forth (see Appendix 4). All the interviews were recorded with each participant's agreement. Interview questions were as follows⁴¹:

1. What images do you think people have of mental illness or people with it?
2. Have you told your diagnosis to others? Could you tell me why or why not?
3. Have the relationships between you and others changed after you told them that you had a diagnosis of mental illness? If so, how have they changed?
4. Have you done something because you did not want to be prejudiced or discriminated against (for instance, concealing your diagnosis)?

⁴⁰ Full ethical approval was obtained from the King's College London Research Ethics Committees before commencing the interviews (SSHL/13/14-6).

⁴¹ Prior to the interviews, I explained to the participants that the present study used the concept of stigma and this concept contained prejudice, discrimination and ignorance. However, I used the words prejudice, discrimination and ignorance or lack of knowledge in the interviews, avoiding using the word stigma, as this word is not very familiar to people in Japan.

5. Have you been treated differently to others in a negative sense or have you been told negative things because you have a psychiatric diagnosis or because of others' lack of knowledge about mental illness? If yes, could you tell me how it happened and how you felt about it?
6. Do you think there are any differences between prejudice and discrimination against mental illness in the past and those in the present? Also, do you think people know more about mental illness nowadays than before?

After these questions, the participants were also asked to talk freely about their experience, feelings and thoughts concerning prejudice/discrimination against and/or ignorance about mental illness. Interviews took between approximately 25 and 50 minutes, with an average duration of 38 minutes.

4-4-3. Method of analysis

Interview data were analysed employing the grounded theory approach (Corbin and Strauss, 2008). The grounded theory approach is one of the descriptive-interpretive approaches used in qualitative studies (Elliott and Timulak, 2005, pp. 147-148). Its characteristics are related to developing theory, which is relationships between categories, through analysis (Morse, 2009, pp. 13-15; Starks and Trinidad, 2007). The present study chose the grounded theory approach over the interpretative phenomenological approach (IPA), the latter of which aims to understand how individuals perceive or account for an event or state using a small sample (Smith, Flowers and Larkin, 2009). The first reason for this related to the fact that the present study aimed to obtain more generalisable findings rather than a detailed explanation of each participant's experience; secondly, while IPA aims to use homogeneous sampling, it was thought it would be difficult to recruit people who had similar perceptions, management and experiences of stigma.

A recording of each interview was transcribed verbatim and each transcript was read several times from beginning to end. The transcripts were then divided into segments, using natural breaks as cutting off points, in order to code them. When analysing data, I wrote a detailed memorandum about coding. Each segment was coded for concept(s) and for properties and dimensions of the concept(s). Concepts are words that summarise ideas contained in data, whilst properties refer to the characteristics or components of an object, event or action, and dimensions refers to variations within properties (Corbin and Strauss, 2008). Concepts and categories were reviewed as the results of the analysis accumulated

and changed, discarded or new ones were added. Concepts and categories were also linked or elaborated by comparing concepts or categories in one interview case, comparing them across interview cases, and reviewing memoranda.

Table 2. Demographic, diagnostic and employment profile of participants

	Men	Women
	<i>n</i>	<i>n</i>
Diagnosis		
Schizophrenia	8	4
Depression	2	6
Age (years)		
20-25	0	1
26-34	4	7
35-44	4	1
45-54	0	1
55-64	0	0
65-74	2	0
Employment status		
Under job training	4	1
Sheltered job	1	0
Job for people with disability or disorder*	3	1
Employed (full time)	1	4
Employed (part time)	0	1
Looking after home	0	1
Unemployed	1	2

* Some companies have a special recruitment policy for people with disabilities/disorders, including those with mental illness. This is not a sheltered job, and yet people who were employed in this recruitment may deal with less complex work than other workers do, with a lower salary than other workers.

When analysing data, a core category under which all of the three elements (perception, management and experience) could be situated was sought, in addition to examining the relationships between the categories.

After analysing the first six sets of data, a core category, which was ‘One of the difficulties when living with a label of mental illness’ was created. However, analyses of another four data sets showed that the participants’ stories did not pertain solely to the difficulties related to a label of mental illness. They appeared to be dealing with three burdens: illness symptoms, psychiatric diagnosis and stigma. Analysis of the remaining 10 interviews further revealed that the change of self-perception had significantly affected participants’ lives; participants’ self-perception had changed, at least partially, after they had been diagnosed with mental illness. Based on this finding, a final core category, namely ‘living with the self that has changed because of mental illness itself and psychiatric diagnosis’ was created.

In developing the final core category, one category (‘change of self-perception’),

which seemed important for explaining the perception, management and experience of mental illness stigma, was analysed for their context, process and consequences. Corbin and Strauss (2008) define context as the sets of conditions which cause problems or circumstances to which individuals respond by means of action/interaction/emotions. They also define process as ongoing responses to problems or circumstances, while consequences are deemed to be the results of the process. The analysis was conducted by reviewing interview transcripts, memoranda and the literature regarding mental illness in Japan.

Following these analyses, a theory about the perception, management and experience of mental illness stigma was developed based upon the relationships between the categories. The theory was checked for gaps in the logic and they were filled in by reviewing all the transcripts and memoranda.

In summary, the refined theory is:

Participants' self-perception changed because of experiencing symptoms of mental illness and accepting psychiatric diagnosis; they came to regard themselves as mentally ill. However, as they were aware of the negative images of their illness in society, they anticipated stigma and therefore most of them chose selective disclosure, while in some cases participants chose indiscriminate disclosure. The choice of selective disclosure depended on their fear of loss of something important and their hope (how they wanted others to regard them and how they wanted to be). Underlying their hope were comparisons between themselves and others in general, or between themselves in the present and in the past. Indiscriminate disclosure depended on their belief (showing that people with mental illness are not different to others would lead to less stigmatising attitudes against mental illness) or how content they were with themselves. Participants' choice of selective or indiscriminate disclosure led to a variety of responses from others, including being treated as before, being treated as someone who needs care, and being treated as not ill but lazy or as different to others.

This theory is described in full in Chapter Six, where the findings of the interview data analysis are presented.

The refined theory was examined to establish whether it fits all the cases and

confirmed that the theory could be applicable to all the cases of the participants. Thus, the theory offered one of several possible explanations about the perception, management and experience of mental illness stigma in Japan. The theory also seemed to have been well developed for the purpose of the interview study, which is to understand the relationships between the perception, management and experience of stigma and what lies behind each element. It was therefore concluded that further data would not be necessary for the present study.

4-5. Summary

This chapter has presented the methods employed in the present study. The study employed document analysis of newspaper articles in order to examine the time trends of social attitudes towards mental illness and document analysis of magazine articles to examine the perception, management and experience of stigma among people with mental illness and their changes over time in Japan. In these analyses, the present study used qualitative content analysis, whereby coding frames were developed based on the existing frames or the content of the random articles. Twenty qualitative interviews with people suffering from either schizophrenia or depression were also conducted in order to understand their perception, management and experience of stigma in detail. In terms of analysing the interview data, the present study employed the grounded theory approach and examined the relationships between the categories.

CHAPTER FIVE: THE PORTRAYAL OF MENTAL ILLNESS IN NEWSPAPERS IN JAPAN

This chapter presents the findings of the analysis of newspaper articles and discusses them while making comparisons with prior studies.

5-1. Changes in story themes between 1987 and 2014

Table 3 shows the changes in story themes from 1987 to 2014. Overall, although articles which came under the category ‘dangerousness’ occupied a high proportion throughout the period, the proportion decreased significantly across the period, from 59% in 1987 to 35% in 2014 (Mantel-Haenszel $\chi^2 = 11.284$, d.f. = 1, $p = 0.001$). Thus the hypothesis was supported. In the ‘dangerousness’ category, ‘suicide and self-injury’ showed a particularly large decrease between 1987 and 2014, from 29% to 2% (Mantel-Haenszel $\chi^2 = 42.178$, d.f. = 1, $p < 0.001$). It should be noted, however, that most of articles with a ‘stress caused by work’ theme reported that an individual with mental illness had killed himself/herself, and that a court, the Labour Standards Inspection Office, or medical professionals judged that the illness had been caused by work-related stress. Furthermore, the proportion of these articles increased from 0% in 1987 to 11% in 2014. Thus, the proportion of articles focussing upon suicide of a person with mental illness decreased, while that of articles focussing upon the relationship between the mental illness of an individual who committed suicide and work-related stress increased over the sample period.

In the group ‘understanding of/concern for mental illness’, although the proportion of articles in the ‘understanding mental illness’ category increased across the sample period (from 19% in 1987 to 36% in 2014), the increase was not significant at the alpha threshold following a Holm-Bonferroni adjustment (Mantel-Haenszel $\chi^2 = 7.194$, d.f. = 1, $p = 0.007$). In the ‘understanding mental illness’ category, articles featuring individuals and groups affected by the illness showed a particularly large increase between 1987 and 2014 (from 6% to 20%) (Mantel-Haenszel $\chi^2 = 11.284$, d.f. = 1, $p = 0.011$). The proportion of articles in the ‘mental illness as stress-related illness’ category significantly increased from 1% in 1987 to 13% in 2014 (Mantel-Haenszel $\chi^2 = 17.823$, d.f. = 1, $p < 0.001$). On the other hand, there was no trend in the proportion of articles in the ‘services, institutions and Laws’ category.

The proportion of articles in the ‘dangerousness’ category decreased across the

sample period for all the four newspapers (Table 4). The Yomiuri newspaper showed a significant reduction between 1987 and 2014 from 89% to 57% (Mantel-Haenszel $\chi^2 = 17.447$, d.f. = 1, $p = 0.001$). Yomiuri, the best-selling and right-leaning newspaper, and Nikkei, the financial newspaper, showed quite large differences in the proportion of articles in the ‘dangerousness’ category for all four years. The differences were significant in 1987 (Pearson’s $\chi^2 = 11.789$, d.f. = 1, $p = 0.001$) and 2014 (Pearson’s $\chi^2 = 9.219$, d.f. = 1, $p = 0.002$), but not in 1996 (Pearson’s $\chi^2 = 3.903$, d.f. = 1, $p = 0.048$) and 2005 (Pearson’s $\chi^2 = 2.947$, d.f. = 1, $p = 0.086$).

5-2. Characteristics of story themes by diagnosis

Table 5 illustrates variation in coverage by diagnosis. It should be noted, however, that many articles featured no specific diagnosis. More than half of the articles with non-specific references to mental illness fell under the category ‘dangerousness’ in 2005 and 2014, but not in 1987 and 1996. Among the articles with specific diagnoses, depression was most frequently mentioned throughout the period, except for 1987, when neurasthenia occupied the highest proportion. Schizophrenia was the second most frequently featured diagnosis. The proportion of articles about depression in the ‘dangerousness’ category showed a large reduction, from 71% in 1987 to 18% in 2014 (Mantel-Haenszel $\chi^2 = 4.509$, d.f. = 1, $p = 0.034$), whilst the proportion of articles concerning depression in the ‘understanding mental illness’ category increased between 1987 and 2014, from 29% to 48% (Mantel-Haenszel $\chi^2 = 6.494$, d.f. = 1, $p = 0.011$). However, the decreases and increases were not significant following a Holm-Bonferroni adjustment. On the other hand, schizophrenia was reported largely in the ‘dangerousness’ context throughout the period, except for 2005.

Although articles about schizophrenia were more numerous in the ‘dangerousness’ category than those about depression for all four years, the proportional differences were significant only in 2014 (Pearson’s $\chi^2 = 13.671$, d.f. = 1, $p < 0.001$). When articles featuring depression appeared in the context ‘dangerousness’, they often reported the suicide of a person with depression, except for 2014 (87% in 1987, 40% in 1996 and 2005 and 25% in 2014; data not shown in Table 5). In contrast, articles featuring schizophrenia in the ‘dangerousness’ category often reported violent crime committed by a person with schizophrenia except for 1996 (67% in 1987, 25% in 1996, 71% in 2005 and 62% in 2014; data not shown in Table 5). The proportional differences in articles with a suicide theme between articles about depression and those concerning

schizophrenia were significant only in 1987 (Pearson's $\chi^2 = 20.057$, d.f. = 1, $p < 0.001$), although there were large differences in 1996 (Pearson's $\chi^2 = 3.745$, d.f. = 1, $p = 0.053$) and 2005 ($p = 0.008$, Fisher's exact test). The proportional differences in articles with a violent crime theme between articles about depression and those concerning schizophrenia were significant only in 1987 (Pearson's $\chi^2 = 8.132$, d.f. = 1, $p = 0.004$).

Another major characteristic of articles regarding depression is that they often reported that depression had been caused by stress-related to work. All but one of the articles assigned to the 'stress caused by work' theme featured depression (16/17 or 94%), whilst most of the articles falling under the 'stress caused by other reasons' category featured PTSD (11/12 or 92%).

Table 3. Story themes of newspaper articles between 1987 and 2014

	Year								Trend		
	1987		1996		2005		2014				
Themes	N	%			N	%	N	%	χ^2 (d.f.=1)	P	Holm-Bonferroni adjustment
Group 1: Harm to others/themselves											
Dangerousness	66	59%	46	41%	45	40%	39	35%	11.284	0.001	
Violent crime	26	23%	24	21%	28	25%	23	21%	0.064	0.801	NS
Nonviolent crime	0	0%	1	1%	0	0%	1	1%	-	-	
Suicide and self-injury	32	29%	8	7%	4	4%	2	2%	42.718	<0.001	Sig.
Mental illness as legal defence	3	3%	5	4%	2	2%	5	4%	-	-	
Victimisation and severe mistreatment	5	4%	8	7%	11	10%	8	7%	0.967	0.325	NS
Group 2: Understanding of/concern for mental illness											
Understanding mental illness	46	41%	66	59%	67	60%	73	65%			
Understanding mental illness	21	19%	32	29%	32	29%	40	36%	7.194	0.007	NS
Individuals and groups affected by mental illness	7	6%	15	13%	9	8%	22	20%	6.495	0.011	NS
Research advances	4	4%	4	4%	3	3%	6	5%	-	-	
Explaining: cause											
Genetic or biological	1	1%	1	1%	4	4%	3	3%	-	-	
Environmental	1	1%	1	1%	2	2%	0	0%	-	-	

Table 3. Continued.

	Year										
	1987		1996		2005		2014		Trend		
Themes	N	%	N	%	N	%	N	%	χ^2 (d.f.=1)	<i>P</i>	Holm-Bonferroni adjustment
Explaining: treatments											
Biological	1	1%	4	4%	3	3%	3	3%	-	-	
Psychosocial	0	0%	0	0%	2	2%	0	0%	-	-	
Others	1	1%	1	1%	2	2%	1	1%	-	-	
Explaining: prevalence and symptoms	6	5%	6	5%	7	6%	5	4%	0.035	0.851	NS
Mental illness as stress-related illness	1	1%	3	3%	11	10%	14	13%	17.823	<0.001	Sig.
Stress caused by work	0	0%	3	3%	2	2%	12	11%	-	-	
Stress caused by other reasons	1	1%	0	0%	9	8%	2	2%	-	-	
Services, institutions and Laws	24	21%	31	28%	24	21%	19	17%	1.262	0.261	NS
Inadequacies	10	9%	11	10%	3	3%	4	4%	4.598	0.032	NS
Improvements	12	11%	7	6%	8	7%	10	9%	0.147	0.701	NS
Introduction of services/institutions	2	2%	13	12%	13	12%	5	4%	0.529	0.467	NS
Total	112	100%	112	100%	112	100%	112	100%			

NS, not significant; Sig, significant.

Test could not be performed for theme groups with expected cell values < 5.

Table 4. Trend by newspaper

	Year										
	1987		1996		2005		2014		Trend		Holm-Bonferroni adjustment
	n	%	n	%	n	%	n	%	χ^2 (d.f.=1)	<i>P</i>	
Yomiuri Dangerousness	25	89%	13	46%	12	43%	16	57%	17.447	0.001	Sig.
Asahi Dangerousness	12	43%	14	50%	12	43%	8	29%	1.433	0.231	NS
Mainichi Dangerousness	16	57%	13	46%	15	54%	9	32%	2.563	0.109	NS
Nikkei Dangerousness	13	46%	6	21%	6	21%	5	18%	5.198	0.023	NS

Table 5. Variation by diagnosis

	Year										
	1987		1996		2005		2014		Trend		Holm-Bonferroni adjustment
Diagnosis	n	%	n	%	n	%	n	%	χ^2 (d.f.=1)	P	
No diagnosis specified	43	36%	55	45%	51	46%	33	27%			
Dangerousness	14	33%	24	44%	26	51%	17	52%	0.074	0.786	NS
Understanding mental illness	5	12%	4	7%	4	8%	5	15%	-	-	
Mental illness as stress-related illness	0	0%	0	0%	0	0%	0	0%	-	-	
Services, institutions and laws	24	56%	27	49%	21	41%	11	33%	7.536	0.006	Sig.
Depression	21	19%	17	15%	18	16%	44	39%			
Dangerousness	15	71%	5	29%	5	28%	8	18%	4.509	0.034	NS
Understanding mental illness	6	29%	9	53%	8	44%	21	48%	6.494	0.011	NS
Mental illness as stress-related illness	0	0%	3	18%	2	11%	11	25%	-	-	
Services, institutions and laws	0	0%	0	0%	3	17%	4	9%	-	-	
Schizophrenia	13	12%	12	11%	15	13%	20	17%			
Dangerousness	12	92%	8	67%	7	47%	13	65%	0.084	0.772	NS
Understanding mental illness	1	8%	2	17%	8	53%	6	30%	-	-	
Mental illness as stress-related illness	0	0%	0	0%	0	0%	0	0%	-	-	
Services, institutions and laws	0	0%	2	17%	0	0%	1	5%	-	-	

Table 5. Continued.

	Year										
	1987		1996		2005		2014		Trend		
Diagnosis	n	%	n	%	n	%	n	%	χ^2 (d.f.=1)	<i>P</i>	Holm-Bonferroni adjustment
Neurasthenia	28	25%	11	10%	4	4%	0	0%			
Dangerousness	25	89%	9	82%	4	100%	0	0%	-	-	
Understanding mental illness	2	7%	2	18%	0	0%	0	0%	-	-	
Mental illness as stress-related illness	1	4%	0	0%	0	0%	0	0%	-	-	
Services, institutions and laws	0	0%	0	0%	0	0%	0	0%	-	-	
PTSD	0	0%	8	7%	15	13%	4	4%			
Dangerousness	0	0%	0	0%	0	0%	0	0%	-	-	
Understanding mental illness	0	0%	8	100%	6	40%	3	75%	-	-	
Mental illness as stress-related illness	0	0%	0	0%	9	60%	1	25%	-	-	
Services, institutions and laws	0	0%	0	0%	0	0%	0	0%	-	-	
Other diagnoses	7	6%	9	8%	9	8%	11	10%			
Dangerousness	0	0%	0	0%	1	11%	1	9%	-	-	
Understanding mental illness	7	100%	7	78%	8	89%	1	9%	2.643	0.104	NS
Mental illness as stress-related illness	0	0%	0	0%	0	0%	2	18%	-	-	
Services, institutions and laws	0	0%	2	22%	0	0%	7	64%	-	-	

5-3. Discussion

Analysis of newspaper articles revealed that: (1) although articles in the ‘dangerousness’ category occupied a high proportion throughout the sample period, the proportion decreased significantly across said period, (2) articles in the ‘understanding mental illness’ category showed a large proportional increase and those in the ‘mental illness as stress-related illness’ category showed a significant increase across the period, (3) whilst the proportion of articles related to dangerousness showed a large decrease in comparison with articles about depression, there was no trend for those about schizophrenia, and (4) depression was often reported in the context of suicide or work-related stress, whereas schizophrenia was largely reported in the context of violent crime when these articles appeared in the ‘dangerousness’ context. Overall, the results of the analysis suggest that newspaper coverage has been changing in that there is now more reporting of mental illness in relation to stress rather than in relation to dangerousness, particularly for depression. There have also been changes in terms of reporting the personal stories of people with mental illness. Below I will discuss how the findings of the present study can be interpreted in relation to the findings of prior research. Although the studies mentioned in the following discussion have minor differences in terms of their methods of analysis, the majority of them employed content analysis and in this vein their methods are similar enough to compare the results.

One of the findings of the present study, namely that articles reporting dangerousness of mental illness occupied a high proportion throughout the period, agrees with the finding of a Japanese study, which analysed newspaper articles concerning mental illness published between 1992 and 2001. This study found that articles containing the word ‘mental’ in the title were often related to crime reports (Harada, Tokuda and Ishigami, 2002). The finding here also agrees with that of another Japanese study, which revealed that newspaper articles about mental illness often fell under the section for reporting crime and court cases (Harada, Ishigami and Tokuda, 2002).

Although few studies exploring the portrayal of mental illness in the media have been conducted in Japan, a large body of research has examined media images of mental illness in other countries. The findings of the review studies show that, between the 1950s and 2005, mental illness was consistently misrepresented, particularly in the manner that people with mental illness are violent and dangerous (Klin and Lemish, 2008; Nairn, 2007; Pirkis et al., 2006; Sieff, 2004; Stout, Villegas and Jennings, 2004; Stuart, 2006; Wahl, 1992). Indeed, recent studies also found the same result (Goodwin, 2014; Kesic,

Ducat and Thomas 2011; Murphy, Fatoye and Wibberley, 2013; Nawka et al., 2012; Nawková et al., 2012). Although positive images do exist, Sieff (2004) notes that these images are rather exceptional. The finding of the present study, namely that articles reporting dangerousness of mental illness occupied a high proportion throughout the period, is generally in line with those of the aforementioned existing studies. However, the present study also found that the proportion of reporting related to dangerousness of mental illness significantly decreased across the sample period, which agrees with the findings of other existing studies (UK: Goulden et al., 2011; Thornicroft et al., 2013; US: Wahl, Wood and Richards, 2002). Roberts, Bourne and Basden (2013) found that, in contrast with the findings of prior studies (mentioned above), the proportion of articles relating to violent crime significantly increased between 1991 and 2011 in Bermudian newspapers. However, as the authors note, this is probably because of two high-profile events in 2011, the reporting of which significantly contributed to the proportion of articles about violent crime.

The present study also found a significant increase in the proportion of articles about understanding of and concerns for mental illness across the period, which is consistent with the findings of Goulden et al. (2011) and Thornicroft et al. (2013). Although Wittenauer and Carr (2011) found no significant difference in the proportion of articles related to education/prevention nor to medical research between 2000 and 2010 in US newspapers, this may be because they included only articles about schizophrenia in the analysis, while the two studies above also included articles about mental illnesses other than schizophrenia in the analysis. In the present study, only a few articles explaining cause, treatments, prevalence and symptoms were found, while this was also the case for those introducing services and institutions. This situation is identical in newspaper articles in Australia, as some existing studies show that Australian newspaper articles often fail to provide information which people suffering from mental illness may need (Henson et al., 2010; Kesic, Ducat and Thomas, 2011).

Furthermore, the finding of the present study, namely that articles about schizophrenia were often associated with dangerousness including violence, also agrees with those of existing studies (Australia: Cain et al., 2014; Brazil: Dubugras, Evans-Lacko and Mari, 2011; UK: Goulden et al., 2011; South Korea: Park et al., 2012; Italy: Magliano, Read and Marassi, 2011; Spain: Aragonès et al., 2014). As pointed out by McGinty et al. (2014) following their analysis of US newspapers, articles analysed in the present study also usually failed to explain that most people with mental illness were not

violent. The present study also found that there was no trend for articles featuring schizophrenia which fell under the category ‘dangerousness’. It is known that the portrayal of schizophrenia in the media has remained negative over time (UK: Clement and Foster, 2007; Goulden et al., 2011; South Korea: Park et al., 2012). Vahabzadeh, Wittenauer and Carr (2011), however, observed a significant decrease in the proportion of reporting of crime committed by a person with schizophrenia between 2000 and 2010 in five US newspapers. One of the possible reasons for this finding is their focus upon crime articles, whereas similar studies also included other negative articles in their analysis.

With respect to articles about depression, as Goulden et al. (2011) found, most of the articles about depression fell under the category ‘understanding of/concern for mental illness’ in the present study. However, when these articles appeared in the context ‘dangerousness’, they were often associated with suicide. This mirrors the findings of certain prior studies. Indeed, after conducting their corpus analysis of Irish newspapers, Tobin and Lyddy (2014) pointed out that there was a recurring pattern in that youth depression was related to suicide. Rowe et al. (2003) investigated the representation of depression in Australian newspapers, finding that one third of their samples had mentioned self-harm or suicide. The present study also found that most of the articles with the ‘stress caused by work’ theme featured depression. It seems that this is, at least partially, because of the influence of the discourse which started to spread in the late 1990s when concern about overwork suicide (suicide of people who are driven by excessive work to kill themselves) or overwork depression (clinical depression which is regarded as underlying such an act) was heightened in Japan. In this discourse, which psychiatrists played an important role in creating, it is explained that tremendous social stress can cause depression, which may lead to suicide (Kitanaka, 2012). The finding of the present study shows that this discourse is often represented in the context of work-related stress in newspapers.

However, it is unclear whether this finding from the present study is applicable to that of other studies; to the author’s best knowledge, no previous studies have discussed articles about depression in relation to work-related stress. This may be because such articles are hardly found in other countries’ newspapers, in which case this is a characteristic of Japanese newspaper articles. There is also the possibility that such articles do appear in other countries’ newspapers, but researchers did not regard the relationship between depression and work-related stress as notable and therefore did not

create an independent category for these articles.

In the present study, the four newspapers were similar with regard to the trend that the proportion of articles in the ‘dangerousness’ category decreased across the sample period. Yomiuri and Nikkei showed, however, quite different patterns of reporting, with Nikkei including fewer articles in the ‘dangerousness’ category than Yomiuri. The reason for the Nikkei trend, where dangerousness of mental illness is less frequently reported than other newspapers, is that many of their articles about mental illness are related to research advances, causes, treatment and symptoms. This is most likely due to Nikkei’s aim of providing information from which companies such as pharmaceutical chains can benefit, as Nikkei is a financial newspaper. The present study included four national high-circulation newspapers in the analysis, but omitted low-circulation national newspapers, local newspapers and tabloids. Since prior studies found that trends in the content of articles varied between types of newspapers - for instance, stigmatising articles emerged more frequently in tabloids than in broadsheet newspapers (Cain et al., 2014; Nawková et al., 2012) - different results may have been obtained if the present study included other types of newspapers. However, the databases of most of the other newspapers in Japan only contained articles published since 2005, which made it difficult to include a wider variety of newspapers in this study.

5-4. Summary

This chapter has presented the results of newspaper analysis and subsequent discussion in comparison to that of prior studies. The analysis of four newspapers’ articles revealed that, overall, articles about mental illness have been changing, from reporting its dangerousness to reporting personal stories of those affected and the relationship with stress. This trend was particularly true for depression, although reporting of schizophrenia showed little difference over time, with most of the articles being related to dangerousness. Most of the present study’s findings agreed with those of prior studies, including studies analysing foreign newspapers. This suggests that there are some similarities when it comes to the trend of reporting mental illness between Japanese newspapers and foreign newspapers. On the other hand, the present study also found that work-related stress was often discussed in relation to depression, which may be a unique characteristic of Japanese newspapers.

In the next chapter, the findings of analysis of magazine articles and interview data are presented.

CHAPTER SIX: THE PERCEPTION, MANAGEMENT AND EXPERIENCE OF STIGMA AMONG PEOPLE WITH MENTAL ILLNESS IN JAPAN

This chapter reports the findings of the analysis of magazine articles and interview data and compares the findings with those from the analysis of newspaper articles presented in the previous chapter.

6-1. Magazine articles

6-1-1. Number of stories and diagnostic characteristics of the readers

In total, 246 articles, which contained 258 stories, met the inclusion criteria. Figure 5 shows the changes in the number of stories in the three magazines. Most stories included in the analysis were in the readers' columns of said magazines. For 'Zenkaren', the number of stories that met the criteria was 151. The readers' diagnoses was unclear in most cases (90 stories or 60%). Sixty-one stories included the readers' diagnoses: schizophrenia (38 stories or 25%), depression (9 stories or 6%), bipolar disorder (6 stories or 4%) and others (4 stories or 3%). Four readers (3%) had a dual diagnosis. For 'Kokoro no Genki', the number of stories that met the criteria was 95. A total of 31 stories (33%) did not include the readers' diagnoses. Of the stories in which the readers' diagnoses were detected, 32 (34%) were schizophrenia, 24 (25%) were depression, 3 (3%) were bipolar disorder and 3 (3%) were others. In total, two readers (2%) had a dual diagnosis. 'Minna no Iro' had 12 stories that fulfilled the criteria. Diagnoses were unknown in most cases (8 stories or 67%) and there were three stories (or 25%) of people with schizophrenia and one (or 8%) of a person with bipolar disorder. Table 6 shows the coding frame and the number and proportion of stories falling under each category. Table 7 describes the findings related to elements (how stories were told).

Figure 5. Number of articles in three magazines

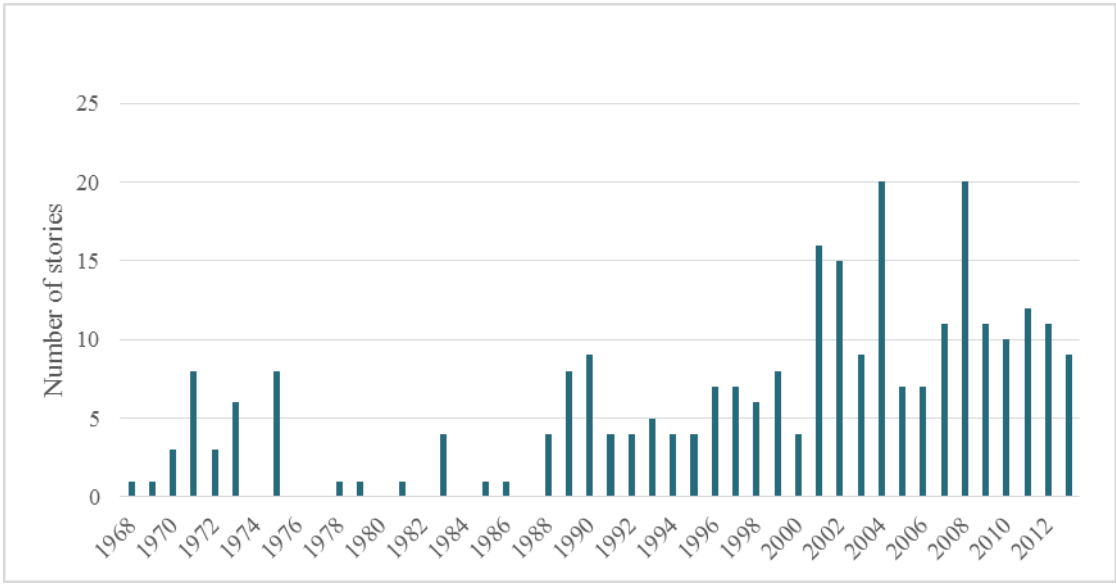


Table 6. Story themes of magazine articles

Categories	N	%
Perception	33	13
Distorted negative images	33	13
Dangerous	20	
Worthless	7	
Others	6	
Management	92	36
Concealment	87	34
At work or when applying for a job	62	
In social or personal relationships	25	
Education	5	2
Educating others about mental illness		
Experience	133	51
Lack of understanding of mental illness	61	24
People do not regard it as illness	41	
People say or do something which could exacerbate symptoms	17	
Others	3	
Loss of a part of their lives	43	17
Work	26	
(Good) relationships with others	11	
Driving licence	2	
Others	4	
Being treated as 'mad' and/or inferior to others	16	6
Being rejected	13	5
Work	10	
Special licence	2	
Others	1	
Total	258	100

Burden of management	N
Physical burden	8
Psychological burden	32
Burden of rescheduling work for receiving treatment	7
Relapse of severe symptoms	6
Total	53

Table 7 Elements of stories

Elements	N	%
Focusses upon their suffering	120	47
Contains both stigmatising and positive experience or perception	63	24
Mentions only their perception, management or experience	45	17
Contains both stigma management and positive experience	30	12
Total	258	100

6-1-2. Findings on story themes

Perceived stigma

Thirty-three stories showed that the readers felt there were distorted negative images of people with mental illness in society or that people regarded them in a distorted negative way because of their illness. When the readers talked about the negative images of mental illness in society, these images were often related to dangerousness. Most of them sensed this in the reporting of an incident caused by a person with mental illness in the media. Below are some examples of these stories:

Once a person with mental illness has committed a crime, the media report the incident very sensationally. They write as if all of the mentally ill are criminals.

(Ms A, schizophrenia, 'Zenkaren', June 1983, p. 14)

Prejudice still remains in society. For example, when a murder happens, the media report that the suspect was receiving psychiatric treatment, and people misunderstand that those affected by this illness harm others.

(Gender and diagnosis unknown, 'Zenkaren', 1990, p. 66)

In the examples below, the first reader describes that she felt that people regarded her as strange because of the symptoms of her illness, whilst the second reader states that people regard the mentally ill as a whole as worthless:

I have always been embarrassed of myself; of the fact that I am a mental patient. Frankly, I still have these feelings. Earlier my mental condition was serious and perhaps it was because I may have seemed absent-minded and had a gloomy expression in my face, people avoided me when I walked down streets or when

I sat on a seat in the bus people sitting next to me changed their seats. I have also been laughed at by upper secondary school students in trains. When I saw myself from the other person's perspective I felt that this is the type of person I am [someone whom people avoid or laugh at] and I hated going out.

(Ms B, diagnosis unknown, 'Zenkaren', October 2001, p. 40)

People regard us as like rubbish. Even patients who live in the same way as normal people do are prejudiced against.

(Ms C, schizophrenia, 'Zenkaren', August 2006, pp. 46-47)

Images other than dangerous, strange or worthless included incompetent, unpredictable, pitiable, inferior to others and shameful.

Management of stigma

The most frequently used method for avoiding stigma was concealment of illness. Whilst most pretended to have no illness, some readers told others that they suffered from physical illness, or a mental illness which they regarded as less severe or less stigmatised than the illness they actually had. Eighty-seven stories showed that the readers had hidden their illness from others, including their colleagues, superiors, friends, family members, acquaintances and neighbours. They most commonly concealed their illness at work or when applying for work. Many of the readers felt the burden of concealing their illness (53/87 stories, or 60%), and a psychological burden, such as anxiety that people might notice that they have mental illness. Indeed, these feelings were particularly common among the participants. The burden led to a relapse of severe symptoms in six cases. Stories about concealment of illness included:

In this magazine there were sometimes articles on 'A Way of Living without Hiding Your Disorder,' but it's something that's just not possible for me. To my neighbours and people I meet in religious gatherings, I say that I got a heart problem but once in a while when we start to talk long and I'm specifically asked where and what exactly is the problem, I break out in cold sweat because I don't want to be specific. My relatives in neighbouring prefectures and in the same prefecture come to see me several times a year. Sometimes they come suddenly

without any advance intimation. At such times, I'd be asked questions such as, 'Where do you work?', 'Do you have a holiday today?', and when they came one could say that it felt like I was suffering in hell.

(Mr A, diagnosis unknown, 'Zenkaren', April 1999, p. 42)

I worked while hiding my illness before. I was the youngest among the workers but I had a responsible position. I couldn't do my duties and I panicked. I finally had a relapse of my illness and resigned six months after I got the job.

(Mr B, diagnosis unknown, 'Zenkaren', November 2003, p. 47)

I started a part-time job in July, hiding my illness. It was so stressful to work while hiding the illness that I got too tired mentally to eat anything or sleep. I quit the job after two months, as I thought it would be impossible for me to continue.

(Mr C, diagnosis unknown, 'Zenkaren', January 2004, p. 12)

Although much less common than the concealment of illness, five readers explained their illness to others in order to obtain their understanding, and in each case the people to whom they explained their illness showed an understanding of it. One of these readers stated:

It was most difficult for me to tell my boss about my condition. Since I had a panic disorder and usually there were no symptoms, so my boss heard what I had to say and replied casually "I see", not listening seriously. As I couldn't get my boss to acknowledge my condition, the burden of work increased and I started getting panic attacks. However, my boss usually asked, 'Why are you sitting idle?' I thought this would further worsen the symptoms and so I consulted the doctor and received a medical certificate. When I had my boss confirm the medical certificate he said, 'Oh, I see. Then let us go to the industrial physician.' Then my boss and I had a joint meeting with the industrial physician. The industrial physician carefully explained to my boss about my illness and asked him to identify work that I could do. From then onwards, my boss asked me 'Can you do this task? Let me know immediately if it's too much for you'.

(Mr D, panic disorder, 'Kokolo no genki', June 2009, p. 16)

Experienced stigma

In total, 133 stories related to the experience of stigma, with a 'lack of understanding of mental illness' being the most frequently told story (61 stories or 46% out of all stories about experienced stigma). In these stories, people did not regard the readers as ill, or said or did something which could exacerbate their symptoms. The readers often experienced this type of stigma within the family. Examples of these stories included:

It has been ten years since I became ill, but my mother never understood how I was feeling. When I told her about my illness for the first time, my mother said, 'You're not ill, you're just weak. You don't need to go to that kind of hospital'. This made me cry. I went to hospital and hid it from her for a while. It (her mother's lack of understanding about her illness) tortured me a lot. I don't know how many times I attempted suicide out of despair.

(Ms D, diagnosis unknown, 'Zenkaren', February 1998, p. 36)

I couldn't stop repeating the same behaviour (because of her illness), although I knew it helped nothing. However, people were cold and my parents scolded me, 'How many times are you repeating the same thing!' I had no idea what to do and found it so difficult that I thought I wanted to die. I even thought about suicide, but I didn't have the courage to do it.

(Ms E, obsessive-compulsive disorder and bipolar disorder, 'Kokolo no genki', January 2009, pp. 18-19)

I became bipolar when I was 19. My father told me that he knew the best way to cure my illness and made unreasonable demands of me. He said, 'Get up two hours before breakfast and clean the entrance hall, and your illness will go away'. But it was impossible for me, as I couldn't even leave my bed because of the symptoms of my illness.

(Ms F, bipolar disorder, 'Kokolo no genki', May 2009, pp. 36-37)

As these examples show, many readers reported that their families lacked an understanding of mental illness. However, there were no readers who had experienced rejection from their families or who had lost contact with them because of their illness.

Another experienced stigma was ‘loss of a part of their lives’: they lost their work or driving licence and so forth, or people left them because of their illness (43 stories or 32% of all stories about experiences). Examples of these stories included:

Thirteen years ago, my friends knew that I had become ill. They changed their attitudes suddenly and left me... I recently recovered, and wrote letters to friends of mine, but got no replies. There were indirect refusals [to my letters] and they simply ignored me. All of my friends who had been on good terms with me treated me like that. The way my friends treated me hurt me deeply and I lost confidence.

(Ms G, diagnosis unknown, ‘Zenkaren’, November 1971, p. 11)

As I needed money and didn’t want to stay at home, I had various part-time jobs, while receiving psychiatric treatment. I once resigned because I couldn’t deal with the work, and at another company, I was fired because they prohibited a person with mental illness from using a knife.

(Ms H, bipolar disorder, ‘Zenkaren’, November 2005, p. 50)

In 15 stories (12%), the readers talked about their experience of being treated as ‘mad’ and/or inferior to others. One reader stated:

When I was staying in psychiatric hospital, what I found hard was the continuous overmedication, and the nurses’ prejudicial attitudes to us. I suffered from their treatment from which I could see they regarded patients as mad, strange and inferior to them.

(Ms I, diagnosis unknown, ‘Zenkaren’, December 1989, p. 16)

Another reader recounted his experience as below:

(After his stay in a psychiatric hospital for two months) I left hospital at the end of July and returned to my work, but they treated me as if I was crazy. They didn’t even give me things to do and I had to leave my job at the end of March.

(Mr E, schizophrenia, ‘Kokolo no genki’, December 2012, p. 52)

In 14 stories (11%), the readers talked about their experiences of being ‘rejected’. This included being rejected from work when applying for a job, having a special licence, renting a room, and not being allowed to attend the funeral of one of their friends because of their illness. One of these readers stated that she concealed her illness when she applied for her current work, for she was refused work whenever she disclosed her illness in a job interview (diagnosis unknown, ‘Kokolo no genki’, August 2011, p. 62). Indeed, another reader, whose diagnosis is bipolar disorder, also stated that he was refused work once he disclosed his illness after being offered a job (‘Kokolo no genki’, June 2007, p. 63).

Another reader recounted his experience of rejection as below:

The president-director of the company to which I applied for employment, told me that they needed people with a qualification to use poisonous and deleterious substances. As I read chemistry at college, I went to a health centre and applied for the qualification. However, they told me that they couldn’t give me the qualification, because the Law prohibits people with mental illness from having it. I didn’t know anything about this, and I was very shocked. I got angry and also felt sad and cried.

(Mr F, diagnosis unknown, ‘Zenkaren’, September 1999, p. 38)

6-1-3. Findings on elements

As we saw in the methods chapter, element refers to how stories are told in the present study. The most frequently discovered element was the suffering of the readers (47%); the focus was upon the emotional pain that they had been subjected to because of the experience, perception or burden of management of stigma in stories with this element. The reason why the readers described their experience, perception or a burden of management of stigma in the context of emotional pain probably lies in the fact that the three magazines are for people with mental illness and/or their families; the readers knew that other people with mental illness would read their stories and they wanted to share their suffering with them. In other words, they expressed experienced or perceived stigma or a burden of stigma management as one of the difficulties which they had because of their illness and wanted to be understood by fellow sufferers. Examples of stories with the suffering element included:

I became depressed in December four years ago. I was aware that I had depression, but people didn't understand it and they thought that I was just lazy. I suffered from their attitudes.

(Ms J, depression, 'Kokolo no genki', February 2008, p. 63)

I have had this illness for 10 years, but fortunately I got a job and I'm working without problems. But I've kept my illness secret at work. Otherwise I would never have got a job. I feel sorry for colleagues when I go to the office later than usual or miss work because I'm ill. I always feel lonely because I haven't told anyone about my illness and I can't talk about it to people at work. I'm anxious about the future.

(Ms K, diagnosis unknown, 'Kokolo no genki', June 2011, p. 60)

I work for a warehouse company full-time. I found this work through a job centre. I've been working for one year and nine months. I haven't said that I go to psychiatric clinic at work. I now have much more work than before. I struggle to deal with it every day. I sometimes work while crying.

(Mr G, diagnosis unknown, 'Kokolo no genki', February 2012, pp. 62-63)

The second most common element was related to both stigmatising experience or perception and positive experience or perception (24%). In stories with this element, the readers stated that they had experienced or perceived stigma, but that they had also received a favourable reaction from people who knew that they were mentally ill. This suggests that they tried to tell their fellow sufferers that not all people were cruel and there were people who were understanding of their illness. Examples of stories with this element were:

Although I told my neighbours that I had illness, I didn't say that it was mental illness. However, I think almost everyone knew that it was. There were people who ignored me, but most of them were kind to me... Maybe people understand mental illness more than we (people with mental illness) think.

(Ms L, diagnosis unknown, 'Zenkaren', August 2002, p. 15)

My fiancé has no prejudice against mental illness and he is happy to go to

hospital with me...There were people who changed their attitudes and left me after I told them that I had mental illness. However, not everyone is like them. There are people who understand mental illness, too.

(Ms M, diagnosis unknown, 'Kokolo no genki', August 2012, p. 61)

Another element was that the readers described their experience, perception or management of stigma without mentioning their opinions or feelings about it (17%). In stories with this element, the readers simply stated how they had experienced, perceived or managed stigma. For instance, one reader stated:

I graduated from university, got a job in a bank and was working enthusiastically when I was diagnosed with schizophrenia. After four months of treatment, I returned to work. As my work was still highly evaluated by the bank at this time, I didn't have to resign. After this I was at the bank for about five years, but human relationships were strained and I got afflicted next with what was more like neurosis rather than a manic state. As I had been hospitalised twice due to mental illnesses, the bank judged me as incapacitated and I was discharged.

(Mr H, atypical mental illness, 'Zenkaren', June 2003, p. 39)

The fourth element was related to their stigma management and positive experience (12%). There were two types of this element. The first pertained to the situation whereby the readers concealed their illness but disclosed it later to others and people accepted their illness. Another was that the readers concealed their illness at work but found it hard to work while hiding the illness because of the burden; they therefore chose to disclose their illness and to apply for a job for people with disabilities/disorders. The nature of the first type is similar to that of the element about stigmatising experience and positive experience; the readers wanted to tell other people with mental illness that there were also people who were understanding of their illness. The second type, on the other hand, shows how the readers dealt with their problems and obtained positive results; it is a kind of advice which could be useful for other readers. One of the examples of the first type is:

I found a job while hiding my illness. But I felt ill two days after I started to work, and I spoke about my illness to the president-director of the company.

However, he said to me, ‘Don’t worry about your illness’. I thought I was lucky to be able to work for him. Other workers were understanding, too.

(Mr I, schizophrenia, ‘Zen karen’, October 2004, p. 47)

One of the examples of the second pattern is:

[After having had various jobs while concealing illness] I thought I’d like to work while disclosing my illness, because I couldn’t ask people at work for understanding about my illness even when I was ill or was suffering from side effects of medicines when working while hiding my illness...About one year of job hunting yielded results and I was accepted in the ‘Challenge Employment Programme’ by the Ministry of Health, Labour, and Welfare. After exactly two years of work experience, I was fortunate to get transferred to the present company. My present workplace gives me constant consideration with respect to overtime and hospital visits, while keeping in view my condition and the boss and staff also treat me with kindness.

(Mr J, schizophrenia, February 2010, ‘Kokolo no Genki’, p. 51)

6-1-4. Findings on qualitative changes in the perception, management and experience of stigma over time

Overall, there were few qualitative changes in stigma which the readers perceived or experienced. Readers often perceived distorted negative images of mental illness in society, felt other people’s lack of understanding of mental illness, and lost some of their relationships with others and/or their work. There seemed few differences in terms of the nature of stigma that the reader perceived or experienced between the 1970s and 2010s. However, there was a change in the management of stigma over time. Although many readers tried to avoid stigma by concealing their illness throughout the period, since 2007, some readers reported that they had chosen a job for people with disabilities/disorders after they had experienced difficulties working while concealing their illness. This probably reflects a legal change. Until 2006, the Law on Employment Promotion of People with Disabilities included only people with a physical disability or an intellectual disability. However, this Law was revised in 2006, which led to the inclusion of people with mental illness in the Law. Most of the readers who reported having chosen a job for

people with disabilities/disorders after experiencing difficulties working while concealing their illness stated that they found it easier to work while disclosing their illness rather than hiding it; indeed, they felt that if they disclosed their illness then they no longer needed to worry that someone might notice it. Furthermore, they reported that colleagues and superiors were understanding about their illness.

6-2. Interviews

6-2-1. Overall tone of their stories

Although the readers of the magazines often expressed their perception or experience of stigma or a burden of management to avoid stigma as suffering, most of the interview participants did not tell their stories in the same manner. They described their perception, management and experience of stigma in detail and did not mention how they felt about them or gave only a few words when explaining their feelings. I enquired as to whether they would mind my asking them to describe how they felt when their stories lacked comments about their feelings. They were not reluctant to talk about their feelings and gave an explanation for them; with this said, they did not exaggerate how much they suffered from the perception, management and experience of stigma. The only participant who described how painful his experience was had a diagnosis of depression, and he talked about his feelings for as long as he talked about the experience itself.

One of the possible reasons for the difference in the narration between the magazine readers and interview participants is that there may be a tendency to dramatise stories in magazine articles. Furthermore, in terms of the reason why most of the participants did not focus upon their emotional pain in their stories, this can be traced to the fact that they talked not to fellow sufferers but to a researcher, or to people who might read the thesis or an article on the findings of this study once published. They understood that the findings of the study may be published, as I explained this during the recruitment process. They also knew that people without mental illness might read it. Some of the participants told me that they participated in the study because they thought that it might help reduce prejudice and discrimination against mental illness if they talked about their personal experiences and thoughts about stigma. Indeed, it is most likely for this reason that they wanted the author or people who might read it to know how they perceived, managed and experienced stigma rather than how they suffered from it. It might also be the case, however, that they did not talk about their suffering in detail because they

thought that it would be difficult for people without mental illness to understand their suffering.

6-2-2. Perception, management and experience of stigma among the participants

Analysis of interview data revealed that the perception, management and experience of stigma were part of the process of living with the self that has changed because of mental illness and psychiatric diagnosis. The participants' self-perception changed, at least partially, after they noticed they were experiencing the symptoms of mental illness or after they had accepted the psychiatric diagnosis they had received. At the time of the interviews, all the participants had already accepted that they had changed, and they lived with the self that had changed because of mental illness itself and their psychiatric diagnosis. The participants perceived, managed and experienced stigma in the process where they lived with the self that had changed. Figures 6 summarises how the participants came to be diagnosed with mental illness and how they perceived, managed and experienced stigma.

In the following section, the perception, management and experience of stigma will be explained in terms of *context*, which is the background of the perception, management and experience of stigma among participants, *process*, which refers to how the participants reacted to problems they faced after they had accepted that they were ill and *consequences*, which pertains to what they received as a result of their reactions. Following these, some comparisons between the experience of people with schizophrenia and those with depression will also be presented. When providing accounts from the interview data, a pseudonym will be used for each participant to protect their privacy.

6-2-3. Mental illness in contemporary Japanese society: macro context of the perception, management and experience of stigma among the participants

Views on mental illness in contemporary Japanese society influenced the perception, management and experience of stigma among the participants. As we saw in Chapter Five, the depiction of mental illness in the media is distorted, with dangerousness of people with mental illness being more frequently reported than their personal experience or

recovery stories. Lay people in Japan are often prejudiced against people with mental illness, particularly against people with schizophrenia (Griffiths et al., 2006; Kurihara et al., 2000; Kurumatani et al., 2004). There are few opportunities for lay people to receive education on mental health/illness at school or to have contact with people with mental illness in Japan. Views on mental illness, however, have been gradually changing. This is particularly true for depression. As Kitanaka (2012) points out, depression became ‘one of the most talked about illnesses in recent Japanese history’ (p. 2) , with a rapid increase in the number of people who were diagnosed with depression as a result of excessive work and took their own lives in the late 1990s.

Figure 6. Living with the self that has changed (until receiving diagnosis)

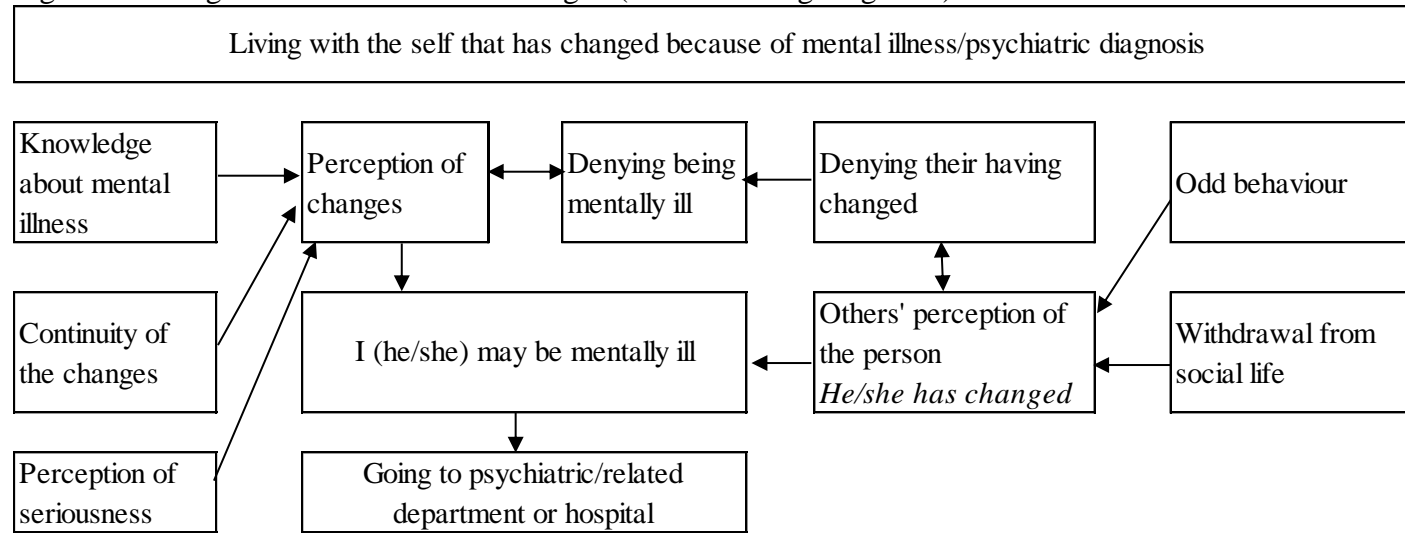


Figure 6. Continued. Living with the self that has changed (after receiving diagnosis 1)

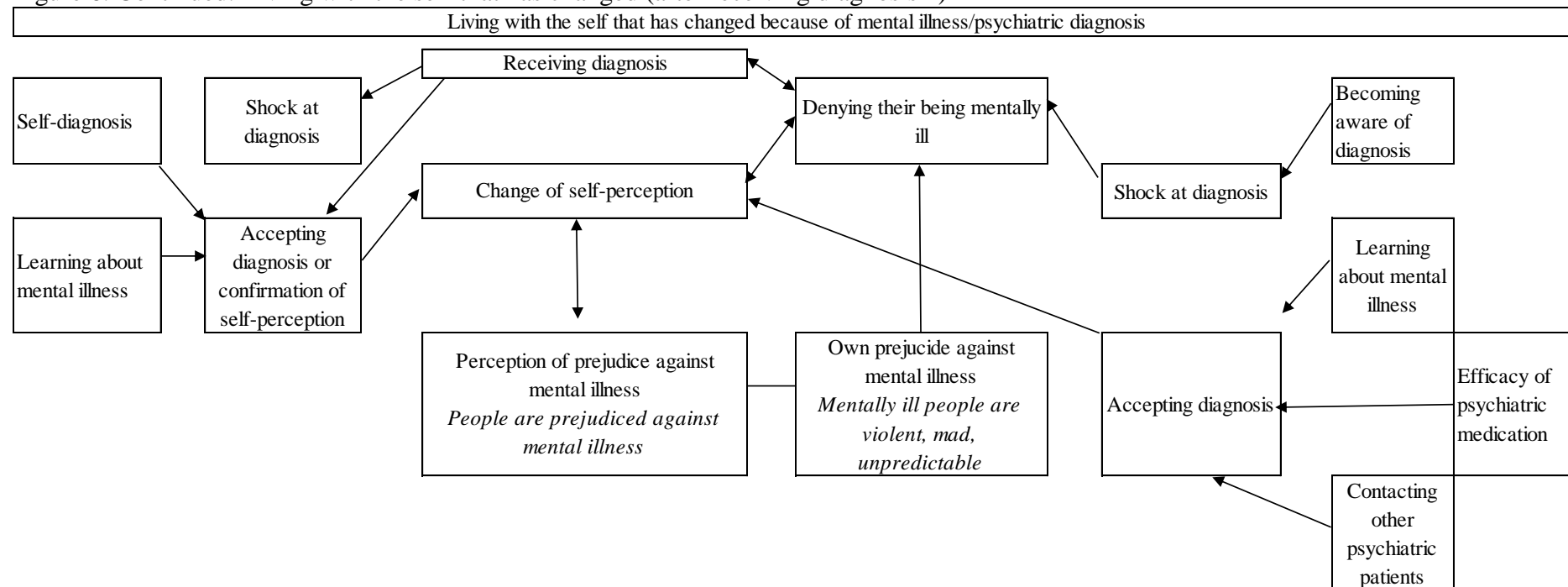
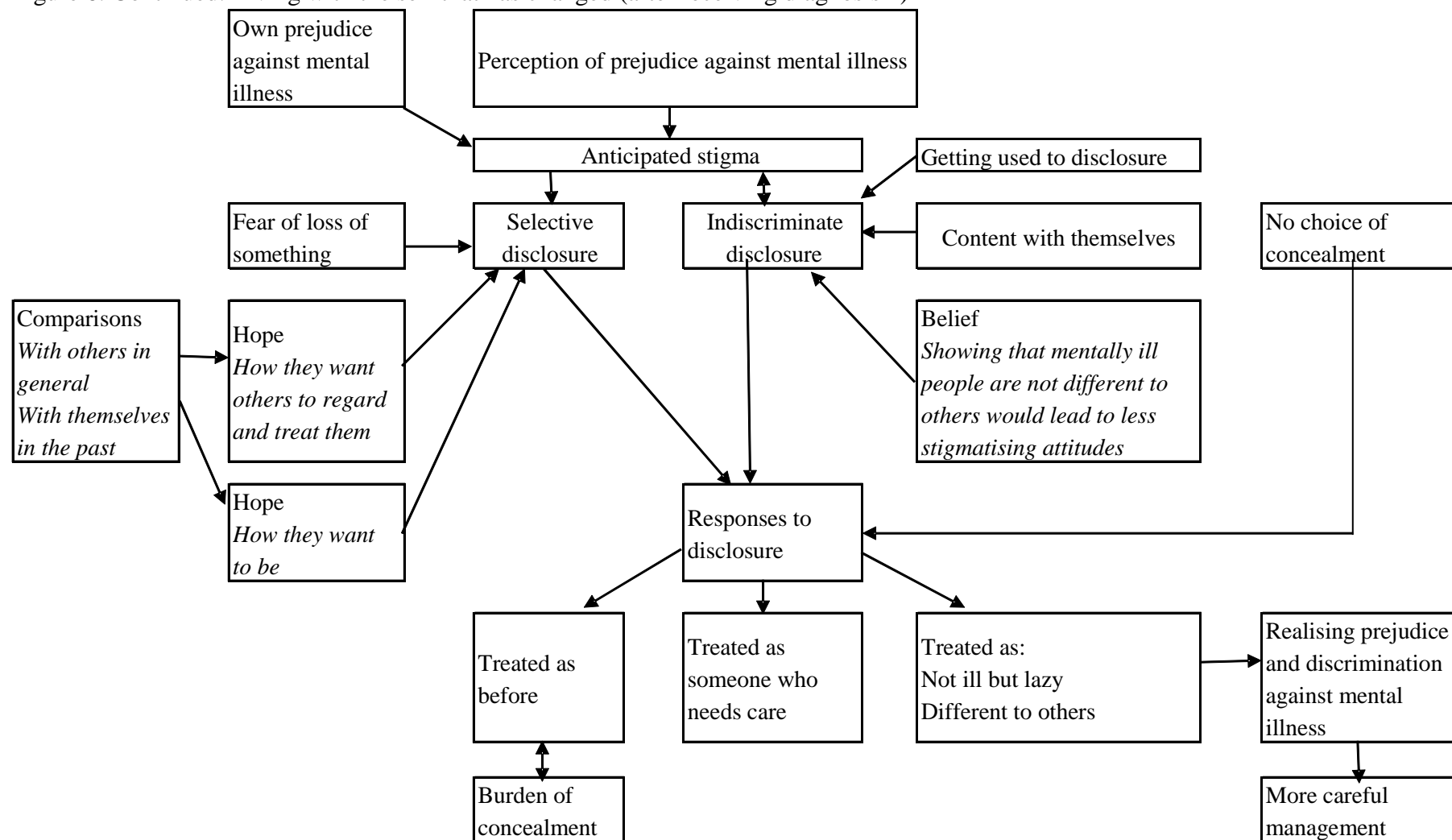


Figure 6. Continued. Living with the self that has changed (after receiving diagnosis 2)



All of the interview participants were aware of the negatively-distorted images of mental illness in society; they understood that people generally regarded those affected by mental illness, particularly schizophrenia, as dangerous, violent or unpredictable. Images of depression were mentioned by seven participants, and yet their view was that such images were different in their nature. Three of them thought that images of depression were generally better than those of schizophrenia and people with depression were generally viewed as gentle, sensitive or vulnerable to stress. Moreover, four of them thought that those affected by this illness were generally viewed as weak, shameful or lazy. Whilst the first three participants thought that images of mental illness varied between psychiatric diagnoses, the remaining four participants thought that mental illness, regardless of the diagnosis, was regarded as negative. Most of the participants (n=18) stated that people knew more about mental illness nowadays than in the past. Half of these participants (n = 9) were unsure whether the increase of knowledge about mental illness had resulted in favourable attitudes towards those affected or that the increase of knowledge had not necessarily led to less stigmatising attitudes towards mental illness. Two of them, for instance, stated that people might regard mental illness as more dangerous or fearful by knowing more about the symptoms of the illness, such as hallucinations and hearing voices, than before. On the other hand, another nine participants believed that there had been favourable changes in social attitudes towards mental illness. The latter nine participants felt that people now know about mental illness more than they used to, mainly because of an increase in the number of educational programmes focussing upon mental health/illness on television or the radio or such articles in the newspaper. Four of these participants thought that an increase in the number of people diagnosed with mental illness, particularly depression or panic disorder, had also helped people pay attention to mental illness and accept it. Of the nine participants, one participant stated that the favourable changes were true for mental illness as a whole, including schizophrenia. However, others thought that whereas depression was well known and understood, schizophrenia remained an unfamiliar illness for lay people.

When asked whether they thought there had been changes in prejudice and discrimination against people with mental illness between the past and present, all the participants gave the same opinion to the author. They felt that people with mental illness were less prejudiced and discriminated against nowadays than in the past. The reasons for their opinions included more favourable or at least less prejudicial reporting of people with mental illness in the media, an increase in the number of services for those affected,

and an increase in the opportunities for people with mental illness to have a job, and so forth. Seven of the participants had heard how badly people with mental illness were treated in the past from their co-patients and/or other people with mental illness they had met in mental health day care services or in a self-help group. When comparing the bad treatment in the past (staying in psychiatric hospital once someone became mentally ill for several decades while being unable to find a place to live and a job) with the treatment they were receiving now (there are services which help people with mental illness to live in the community and there are also jobs for them), these seven participants thought that those with mental illness were now less prejudiced and discriminated against.

Whilst all the participants believed that people with mental illness were now less prejudiced and discriminated against than in the past, they also felt that mental illness still had negative and distorted images. These two thoughts seemed to exist in parallel among participants. For instance, Ritsu, who was diagnosed with schizophrenia, stated that people with mental illness were regarded as violent and dangerous and that 'normal' people did not understand what schizophrenia is like. Because of the belief regarding negative images of mental illness and the thought that people lack an understanding of schizophrenia, he did not disclose his diagnosis and history of psychiatric treatment other than to his immediate family. He was also reluctant to show his booklet, which certifies that he is mentally ill, to a driver for a discount off the bus fare. However, when asked whether he felt that there had been any changes in prejudice and discrimination against mental illness, he answered:

People say it [schizophrenia] is the illness one in every one hundred people can be affected [by], so, I don't suppose it's prejudiced against so much now. When I go to a convenience store, I sometimes see such people [people who seemingly suffer from schizophrenia] working there. So, I've come to think it's likely for us [people with schizophrenia] to have a job...I think mental illness has been relatively known [by lay people]. It's true that the number of people with depression or panic disorder has been quite increasing, isn't it? There are these many young people with mental illness too, so, I think that prejudice against mental illness has been eased these days.

In the same way as Ristu, all other participants thought that prejudice against mental illness had been eased on the one hand, but also felt that prejudice against and negative

images of mental illness did still exist. It seemed that the participants had been aware both of the changes in social attitudes towards mental illness and unchanging attitudes towards it.

The statement from the participants - people with mental illness are less stigmatised today than in the past - contrasts with one of the findings in the analysis of magazine articles. It appeared that there had been few qualitative changes in the perception and experience of stigma from the content of the magazine articles. One of the possible explanations for this is that the interview participants might have been referring to the frequency; they might have meant that people with mental illness would face stigma less frequently nowadays than in the past. It should also be noted that magazine authors may be more likely to have stronger views about stigma than interview participants and that there may be a tendency to dramatise stories in magazine articles.

With respect to the participants' awareness of social attitudes towards mental illness, differences between social attitudes in large cities and those in small towns were also found. There were two participants who mentioned these differences. One of them, Yūya, who was diagnosed with depression when he was at college, had been born in Tokyo but his family had moved to a small town in the middle of Japan (300 kilometres away from Tokyo) when he was five; he had lived there until he went to Tokyo in order to study at a college there. Since then he has lived in Tokyo for approximately 15 years. He described the small town he used to live in as 'a closed town where you won't find it comfortable to live'. He explained the differences between people's attitudes towards mental illness in Tokyo and those in the small town where he used to live:

There's a difference between the countryside—the so-called 'insular' countryside—and a place like Tokyo, whose residents are from various places. In the countryside, people think that those with mental illness are completely violent and dangerous. There's a climate along the lines of, 'Don't go near that person'. This exists in the area I lived. People [in the area] do not even understand depression. They say that mental illness emerges because people are weak-willed, and those who are told so believe it...In Tokyo, it's a given—it's not rare. There didn't seem to be that bad of an image regarding things that you frequently hear about like depression and panic disorders. As might be expected this isn't the case with schizophrenia: its image is different. But if a person is suffering from depression or a panic disorder, it's my feeling that people would

treat you as normal in Tokyo.

Yūya's belief about attitudes towards mental illness in Tokyo depended largely upon his experience at work. He had had several jobs after he graduated from college. At a company he was working for, he disclosed his illness to his colleagues and superiors, who showed understanding of his condition and cared about him. He had once disclosed his illness in a job interview. The employers did not care about it and hired him regardless. Colleagues and superiors at this company, who knew that Yūya had been diagnosed with depression, were also sympathetic to him. He had never been prejudiced or discriminated against at work because of his illness.

Another participant, Mika, who was diagnosed with depression, was from a small town in southern Japan (1,000 kilometres away from Tokyo) and came to Tokyo in order to study at a college there. She has lived in Tokyo since then for about ten years. Similar to Yūya's statement above, she felt that prejudice against mental illness was more intense in her hometown than in Tokyo. She stated that people with mental illness, regardless of their diagnosis, were regarded as 'mad' in her hometown. Mika became ill after she went to Tokyo. Her friends in Tokyo were supportive and understanding even after she disclosed her illness, and she had never been treated differently in Tokyo because of her illness. Her experience in Tokyo led her to think that in Tokyo, mental illness, at least depression, is not stigmatised as much as in her hometown. These two participants' thoughts suggest that social attitudes towards mental illness can differ not only because of the times, but also because of location. Although no research has compared social attitudes towards mental illness between Tokyo and another city in Japan, a study by Zenkaren (1998), which employed a nationally representative sample, found that respondents living in cities with a population of more than 300,000 had shown significantly higher levels of acceptance for autonomy and social participation of people with mental illness than those living in smaller cities. This result suggests that social attitudes can vary between large cities and smaller towns, with the residents in large cities being more accepting of people with mental illness than those in small towns.

However, whilst social attitudes towards mental illness in Tokyo may differ from those towards mental illness in other areas of Japan, Tokyo is not very different from other areas in terms of the patterns of mental health care. For instance, the average duration of psychiatric hospitalisation was 213 days in Tokyo in 2011, which is only slightly shorter than the national average (296 days; MoHLW, 2012b). Furthermore, although the number

of psychiatric hospitals per 100,000 of the population in Tokyo (0.4) is half the national average (0.8), the number of psychiatric beds in general hospitals per 100,000 of the population in Tokyo is the same as the national average (0.8; MoHLW, 2012a). Thus, whereas people may be more accepting of those with mental illness in Tokyo, where the interview participants lived, than in other areas, they were receiving treatment in an environment which is similar to that of other areas in Japan.

6-2-4. Accepting changes in themselves and receiving treatment: personal context of participants' perception, management and experience

The stories of the interview participants showed that, broadly speaking, there were two patterns in terms of how they came to be diagnosed as mentally ill by medical professionals. With regards the first pattern, participants noticed changes in themselves, which included insomnia, suicidal thoughts and/or hearing voices. They thought that these changes might be caused by mental health problems and sought a diagnosis. They went to a medical institution, where they were given possible medical explanations about their changes. The second pattern involved other people, in most cases the participants' families, noticing the changes in the participants and taking them to a doctor in order to obtain possible explanations. In this case, even if the participants had been aware of the changes, which were mostly cognitive changes such as hearing voices and delusions, since before their first visit to hospital, most of them did not think that *they* had changed. They thought that other people and/or the world around them had changed. For instance, Yuzuru, who was diagnosed with schizophrenia, had been thinking that his mother was a spy who was listening to everything he had said. In other words, he thought that his mother had changed or the world around him had changed. Although there were also participants who had thought that they had changed, those who were diagnosed with mental illness with the second pattern tended not to think or admit that the changes had been caused by mental health problems, at least for some time after their first visit to hospital. In most cases the diagnosis was not given to them for several years, although their families were informed of it. Generally speaking, the first pattern was characteristic of the participants with depression, whilst the second was seen only in the participants with schizophrenia.

In terms of the participants who received a psychiatric diagnosis with the first pattern (n = 12; eight participants with depression and four participants with

schizophrenia), their self-perception had changed at least partially between before and after they became ill. The participants experienced physical, psychological and/or cognitive changes, and came to regard themselves as mentally unwell because of the changes. The concrete examples of the changes included insomnia, fatigue, intense anxiety, feeling depressed, suicidal thoughts and hearing voices. For these participants, the changes were unusual, not normal things, which they felt may have required medical treatment. All but one regarded themselves as mentally unwell, mainly because of the unusual changes in emotional aspects. The remaining participant (Yukiko), who was diagnosed with schizophrenia, thought of herself as mentally unwell because of the unusual changes in emotional and cognitive aspects (hearing voices). She had a sister who had been diagnosed with schizophrenia and knew the symptoms of schizophrenia. She stated that she had thought that she might have been suffering from schizophrenia when she realised that she was experiencing the same changes that her sister had done. In addition to the unusualness, duration was also a reason why participants thought that they might need professional help. For instance, Ruri, who was diagnosed with depression, described her experience as below:

I think it took me several weeks, or perhaps a month, to go to a psychiatric department. Until then, I had been suffering from intense anxiety. It wasn't normal anxiety, it was so intense...at that time, I woke up every morning before my alarm rings. And then I felt very anxious in bed. My chest felt as though something were pressing on it. Because the anxiety was so intense, I thought I even wanted to die to avoid feeling it. If I had felt the anxiety once or twice, I wouldn't have thought that I had been suffering from depression. But it came to me every morning for several weeks. Then I thought, 'I'm probably depressed'.

Like Ruri, persistency or recurrence of the changes was a key factor for these participants when it came to seeking professional help. When seeking this help, they chose to go to a psychiatric or related hospital or department. This suggests that they expected that their changes (or symptoms) came from mental health problems rather than physical health problems.

Among the participants who received a diagnosis with the first pattern, some of them did not feel that they had experienced changes in anything other than their physical, psychological and/or cognitive state (for instance, ability to work). In contrast, the

remaining participants felt that other aspects had also changed. In any case, these participants knew that they had changed physically, psychologically or cognitively and wanted to be cured or at least to control their symptoms. They accepted that medical treatment was one of the choices for recovery or keeping their symptoms at a level which they could deal with during everyday life. As such, they adhered to the treatment suggested by their doctor. Among the participants with depression, all were told their diagnosis by their doctor. In terms of the participants with schizophrenia who received a diagnosis of schizophrenia with the first pattern, there was one participant who was not told his diagnosis, whereas the remaining three participants were told their diagnosis. The participant who was not told his diagnosis was unaware of it for several years, while receiving psychiatric treatment. He became aware of his diagnosis not through his doctor but through his patient record. Generally speaking, whilst the diagnosis of depression was relatively acceptable for the participants with depression, the participants with schizophrenia were shocked by or confused with their diagnosis. This is described in detail later, in the section entitled 'Comparison between the participants with schizophrenia and those with depression'.

With regard to most of the participants who received their diagnosis with the second pattern ($n=8$), in which they were taken to hospital by other people, their self-perception had not changed at least until some time after their first visit to hospital. They did not think that they were mentally unwell, and regarded themselves as healthy. Although there were two participants who thought that something was changing in them (for instance, insomnia or being depressed), they did not think or admit that these changes had been caused by mental health problems.

According to the participants' thoughts, one of the major reasons why other people (in most cases families) sensed that the participants might be mentally ill was their 'odd' behaviour and the reasons for the behaviour, which other people could not understand. 'Odd' behaviour included searching for a wiretap at home and sitting at the same place almost all day at home, doing nothing. The participants had a reason for their behaviour - for instance, one participant believed that he had been tapped - and yet other people could not understand it, probably because the participants' reasons for their behaviour were significantly different from other people's recognition of the reality. The participants also believed that other people had thought that the participants might have been mentally ill because it had become difficult for the participants to lead a social life as they used to. The participants who had been working had to resign from their job,

whereas those who had been students had to withdraw from college because of their symptoms. Their families appeared to have suspected that the participants were ill, as they found it difficult to lead a social life and the families were worried about the participants who stayed at home, doing nothing.

In the same way as the participants who received a diagnosis with the first pattern chose to go to psychiatric or related hospitals or departments, other people, mostly families, also took the participants to psychiatric or related hospitals or departments in the second pattern. This suggests that they expected that the participants might be suffering from mental illness.

Among the participants who were diagnosed with mental illness with the second pattern, diagnosis was not given by their doctor at the initial consultation, although their families were informed of it. The participants were usually unaware of it for a long time (range from 2-11 years) while receiving psychiatric treatment. Except for one (Ritsu), who was finally told his diagnosis by his doctor 11 years after his first visit to hospital, these participants became aware of their diagnosis when they saw their patient record or application forms for benefits or the booklet.

Although a survey at five medical institutions in Hokkaido (northern frontier of Japan) showed that 63% of the doctors had reported giving the diagnosis of schizophrenia to their patients in 2013 ($n = 858$; Kako et al., 2014), it was not unusual for them to avoid it, particularly when schizophrenia was called ‘Seishin Bunretsu Byô’ (mind-split disease). A 1996 survey of psychiatrists’ attitudes towards giving a notice about diagnosis to their patients showed that the proportion of psychiatrists who reported giving the diagnosis of schizophrenia to their patients in principal was only 9%, whereas 42% of them reported giving it to their patients when appropriate and 28% reported giving it to their participants’ families in principal⁴² ($n = 119$; Nishimura, 2004). Considering that the participants were taken to hospital and received a diagnosis before the renaming of schizophrenia took place, it is not surprising that they were not told their diagnosis by their doctor.

For the participants who were not told their diagnosis, it took at least several years to accept that they were suffering from schizophrenia after their first visit to hospital. At first, they did not think or admit that they had been suffering from symptoms of illness and often refused treatment, did not adhere to it, or were unsure why they were receiving treatment, even when they accepted treatment. One of these participants, Masaru, who

⁴² The author notes that most of the 1,000 psychiatrists whom she contacted refused to participate in her study, with the major reason being ‘we do not give a diagnosis to patients in our hospital’.

used to work as a psychiatric social worker, stated that he had not adhered to treatment until he admitted that he had been suffering from schizophrenia.

Because I worked as a psychiatric social worker, I knew that [the audio hallucinations etc.] were all symptoms of schizophrenia. But really, I didn't want to admit it [that I had schizophrenia]. I didn't think there was any way that I would turn out to be schizophrenic. Until I was hospitalized, I went to an outpatient programme and was given medication. But I didn't take the medication, and I threw it all away. I lied to my doctor and said that I was actually taking it.

For the majority of these participants ($n = 5$), one of the reasons why it was difficult for them to accept that they became mentally ill was that they were prejudiced against it; they thought that people with mental illness were mad, violent, dangerous or unpredictable, while they did not regard themselves as such.

Their self-perception, however, gradually changed. Although the participants had had little knowledge of schizophrenia when they were initially taken to hospital, they learnt about schizophrenia from their co-patients and/or studied it in books and/or pamphlets and so on after their initial visit to hospital. One participant started to study it before he was told his diagnosis, whereas the remaining seven participants started to do so after they became aware of their diagnosis. For half of the participants ($n = 4$), families were also an important support structure when it came to understanding their illness better; their families collected information about schizophrenia and gave it to the participants. During the process of learning and studying schizophrenia, the participants noticed that what they had been experiencing, e.g. hearing voices, matched the symptoms of schizophrenia, which made them think that they might actually be suffering from schizophrenia. The efficacy of medication also played an important role in their change of self-perception. Knowing that psychiatric medication reduced their symptoms, they came to think that what they had been experiencing might have been caused by mental illness. For example, Ritsu did not know his diagnosis for 11 years and did not regard himself as suffering from schizophrenia over the period. Whilst he was receiving psychiatric treatment as an outpatient during this time, he did not take the medicine suggested by his doctor. In the 11th year, he stopped taking medicine without consulting his doctor, which led to the deterioration of his delusions. He had to be hospitalised for

one year because of this. When staying in hospital he was told his diagnosis. Although he was shocked at the diagnosis, he started to adhere to treatment following this hospitalisation. He felt that medicine worked well in terms of reducing his symptoms when they were taken properly. As such, he eventually realised that, ‘it may be true that I’ve been ill’. This suggests that his identity as a mentally ill person had been influenced by the efficacy of psychiatric medication.

The participants also had the opportunity to contact other people with mental illness in inpatient care, in a self-help group and/or at facilities for people with mental illness in the community since they became patients themselves. From these experiences, the participants knew that not all psychiatric patients were violent and unpredictable as they had thought, and that there were many patients who were gentle, sensitive and well-functioning. Thus, the participants’ perception of people with mental illness changed, which helped to reduce said participants’ hesitation or sense of shame in regarding themselves as someone suffering from mental illness.

At the time of interview, all 20 participants believed that they did indeed have a mental illness. One of the participants, Gorō, who was diagnosed with schizophrenia and did not regard himself as ill at first, described his experience as below:

I think I was first diagnosed with a mental disorder when I was 20, but I just wondered why I was being hospitalized. I think that my family knew about my illness, though. I didn’t think that I was crazy, and I thought I was being [involuntarily] committed to the hospital. So ... when I was hospitalized for the second time, I heard that I was probably schizophrenic from the other people who were around the same age as me [other hospitalized patient]. I didn’t think that I had a mental disorder, and I had never thought of something like this, so I thought it’s nothing, I’m normal. Then I got a call from my mother [when I was in hospital], and even when she asked ‘do you know that you’re sick?’ I thought why they are calling me sick; my body is normal, what about it is sick. Then, after I was hospitalized for the third time, I was finally told [by my doctor] that I had schizophrenia. I had an opportunity to study [about schizophrenia] together with the nurses and other patients with schizophrenia [at the hospital]... I realized what it was, and I finally came to understand [that I have schizophrenia].

Thus, once he had studied the illness, Gorō came to think that he had actually been

suffering from schizophrenia. It seemed that since he had accepted his condition, he had stuck with the self-perception of being mentally ill (or being someone with schizophrenia); it appeared that this perception of the self had been fairly consistent in him over time. Since he came to regard himself as mentally ill, he adhered to treatment and went to the community activity support centre for people with mental illness on a daily basis. Whilst this consistency was also seen in some other participants with schizophrenia, there were two participants diagnosed with schizophrenia whose self-perception had been less consistent. These two participants had once thought that they were suffering from schizophrenia and adhered to treatment, and yet after a while they stopped taking medicine without consulting their doctor, since the symptoms subsided. They thought that the symptoms had been temporary and that they had recovered. It appeared that their self-perception had changed and they had regarded themselves as healthy or someone who had experienced schizophrenia before. However, they suffered a relapse because they had stopped taking their medicine, and this made them realise that they had actually not recovered. Because of the relapse, these participants came to think that schizophrenia was not an illness which was easily curable and that they probably needed to deal with the illness for a long time. Thus, they regarded themselves as mentally ill again. When comparing the changes of self-perception in the participants with schizophrenia to those of self-perception in the participants with depression, unlike some participants with schizophrenia, all of the participants with depression appeared to be consistent over time in their recognition of being mentally ill.

6-2-5. Processes of disclosure and concealment of their illness

Once the participants accepted that they were mentally ill, they had a problem regarding disclosure: whether they should tell others and whom. As mental illness is concealable when symptoms are stable, people do not usually become aware of mental illness without being told. This leaves people suffering from mental illness with the problem of disclosure/concealment. The participants already knew that mental illness was often negatively viewed in the society where they lived and therefore sensed that disclosing their illness to others could lead to negative consequences. Furthermore, although they had accepted that they were mentally ill, it appeared that they regarded the fact of being mentally ill as not socially presentable.

There were two major methods which the participants used when reacting to the

problem: (i) disclosing their illness to some specific people and (ii) disclosing their illness to almost everyone. Each participant chose one of these approaches, depending upon whether they would lose something important to them following disclosure, how they wanted to be regarded and treated by others and/or how they wanted to be. If they thought that they were likely to lose something important to them (for instance, an opportunity to have a job) by disclosing their illness to others, they usually concealed their illness from others. In choosing which approach to take, it was also essential how they wanted other people to regard and treat them and how they wanted to be. For example, if they wished to be regarded and treated as a person without illness by others at least at work and they wanted to work as people without mental illness generally do, they chose not to disclose their illness to others at work. The two approaches to disclosure will be explained in detail in the following sections.

(i) Disclosing the changes to some specific people

This was the most frequently employed method of disclosure among the participants. All of the participants, except for four, told their families that they had received a psychiatric diagnosis. Of the four participants, two did not tell their diagnosis to their family, as they thought that they did not need to (they lived separately from their family). The remaining two went to hospital with their families of their own free will and were told their diagnosis. Since their families were also there, these participants did not need to tell them of their diagnosis.

Except for the cases of the participants above, all of the seven participants living with their family members disclosed their diagnosis soon after they received it, even if they did not accept their diagnosis. They thought it was impossible to hide their illness from family members living with them, particularly when they had symptoms of schizophrenia such as delusions and hearing voices. Two of the seven participants also mentioned that they had wanted their families to understand that they had been suffering from mental illness. These two participants thought that their families would understand why they found it difficult to do the things they did before (e.g. domestic chores), if they told them that they had been diagnosed with a medical illness. One participant, who lived separately from his family, did not disclose his diagnosis to them at first, for he thought that he did not need to. However, he told his family several years later; he became physically ill because of the side-effects of his psychiatric medicine, and it was impossible

for him to hide the physical illness from his family, as it was quite serious. There were no participants who stated that it had been difficult for them to disclose their diagnosis to their family.

There were eight participants whose families, not the participants themselves, were informed of their diagnosis by their doctor at the initial consultation. According to the participants, these families were probably told by their doctor not to disclose the diagnosis to the participants, as the participants would be shocked by it. As such, these participants usually refrained from discussing their illness with their families, at least until the participants became aware that they were ill or until they became aware of the diagnosis. None of these eight participants had asked their families how they felt when they were initially diagnosed with schizophrenia. Because of this, it was not possible to analyse their families' reactions to the initial diagnosis.

Outside of their families, most of the participants (85% or 17/20) chose the people to whom they disclosed their illness. In this way, the participants tried to avoid being stigmatised because of their illness. They hid it from their friends who were not very close, relatives, neighbours, colleagues, superiors at work and so forth. They did so because they wanted to be regarded as 'normal' or as someone without illness or disability and to be treated in the same way as 'normal' people would be. These participants were aware of how *seken*, or others in general, would regard them if they knew that they were mentally ill.

In the case of Sakura, who had a diagnosis of schizophrenia and had a part-time job at the time of her interview (she did not disclose her illness to anyone at work), her family knew that she was ill and she wanted to be treated as someone with mental illness by her family members, since otherwise they would not allow her to continue to work only part-time. Her own honest feeling was that she did not want to work, even at a part-time job, as she did not believe that she had recovered enough and it was hard for her to work. However, her family was having a hard time making ends meet, which left her with no choice other than to hold down a job. She told the author that she used her mental illness as an 'excuse' for not working full-time, but at the same time she also expressed her hope of being regarded as 'normal' by other people.

I want to be ill and I don't want to be ill. I can make an excuse to my family if I'm ill, but *seken* (people) don't think of me as normal if I'm ill. I want to make an excuse, but I also want people to regard me as normal.

By 'normal', she meant being able to work as people without illness or disability generally do. This notion was shared by some of the participants who used the words 'normal' or 'average' (n = 5), although some other participants used these words to mean 'behaving as people generally do' or 'not being different to people without mental illness in their nature' (n = 5). Although not all the participants used the word 'normal' or 'average', it seemed that those who did not use these words were also concerned about being regarded as not 'normal' by others. For instance, Sumire, who was diagnosed with depression, stated that she had worried that her superiors at work might think of her as 'strange' when she disclosed her diagnosis to them.

Many of the participants who chose to disclose their illness only to a small number of people had experience of concealing their illness when applying for a job and/or at work (65% or 11/17). This was partially for practical reasons; they feared that they would otherwise not be able to obtain a job or they might be demoted or dismissed. However, their expectation of how they wanted other people to regard and treat them and/or how they wanted to be also played an important role when choosing the way they dealt with the problem of disclosure. They did not want to be regarded as 'less than average' or negatively deviant; they wanted to be regarded and treated as someone who can work as people without illness or disability generally do or to be regarded and treated as someone who can work as they used to and/or they wished to be thought of and treated as someone who acts 'normally' (for instance, someone who does not act in a violent way).

Their expectations were based on their comparisons between themselves and others in general and/or between themselves in the past and present. Broadly speaking, there were two patterns in their thoughts, developed from these comparisons. The first pattern is that whilst they accepted that they had changed physically, psychologically and/or cognitively, they thought that other aspects in them had not changed or there were only small changes. The second pattern was that they thought that their other aspects had also changed after they became ill. Other aspects mostly meant 'ability to work' for the participants. In terms of the first pattern, it was common for them to think that their ability to work had not changed or had only slightly changed, although they admitted that they did have a mental illness. Because they did not think that they had problems with working as people generally do and with working as they used to, they concealed their illness when applying for a job or in the workplace. They believed that they could work in the same way as other people do and as they did before, and they wanted to be regarded and treated

as such. However, two participants (one was unemployed and another was undertaking job training at the time of interview), wanted to be regarded and treated as someone without illness or disability at work, although they thought that it might be difficult for them to work as people without illness or disability generally do or as they used to. Ritsu, who was diagnosed with schizophrenia and was in his forties at the time of his interview, had held down several regular jobs in his twenties. Although he had not yet been diagnosed with schizophrenia when in these jobs, he thought that he had symptoms of schizophrenia at that time, as he had been hearing voices, but had managed to work. He wanted to have a regular job again and he regarded the job training he was receiving at the time of his interview as ‘one of the trainings for having a regular job in the near future’. When asked whether he was going to disclose his illness when applying for a job, he stated:

Ritsu: I’d have a strong desire to do so [applying for a regular job without disclosing his illness], one more time. While it’s true that physically, mentally, and so on things are different than when I was in my twenties, since I’d worked at three places then, I really want to try having a regular job, even if it’s too much I’d like to give it a try—I can’t leave this [feeling] behind . . .

Interviewer: You are saying that you want to search for a job without disclosing [your psychiatric illness] because you don’t want to be seen from the beginning as someone with a disorder?

Ritsu: That too—yes, I don’t want people to think that I have a disorder. I’d like to choose a workplace that will let me work just like ordinary people, without discrimination.

As he stated, he sensed that it might be difficult for him to have a regular job because of his changes, although he did not mention whether he regarded these changes as resulting from his illness. His statements suggest that he wanted to be treated in the same way as people without illness or disability are, at least at work, despite his recognition of the changes. He made a comparison between himself in the past, who already had the illness but managed to have regular jobs, and himself in the present, who had an illness as before and was undertaking job training. It seemed that his evaluation of himself in the past was higher than that of himself in the present and that he wanted to be the same as himself in the past again. This was also true for another participant (Kazuyo). Kazuyo was diagnosed

with depression and was unemployed at the time of interview, although she had held down several regular jobs when she already had the illness. She wanted a regular job again, although she knew that it would be difficult for her to work as people generally do. It was 'something' for her to have had regular jobs and she felt sad that she could not work as she used to.

Whilst the participants often chose to conceal their illness, they also revealed it to a small number of people. In most cases, the people to whom the participants told their illness were those who were close to them (mostly friends) and/or colleagues and/or superiors at work. When they revealed their illness to those who were close to them, they either wanted these people to accept them and to accept the fact that they suffer from mental illness, or they expected that these people would accept them and their illness because of their close relationships.

When they disclosed their illness to people who were not very close to them, such as colleagues and superiors at work, there were particular reasons for it. Four participants had experience of disclosure of their illness at work. For instance, Ruri, a participant with depression, disclosed her illness to her superiors at work, as she needed to re-schedule her work to be able to see her psychiatrist or counsellor regularly, and also wanted her superiors to understand that she was depressed and needed treatment. She herself understood that she was ill and wanted treatment, but she did not think that she had a problem with dealing with her work because of illness. Therefore, whilst she sometimes went to her office later than usual or left her office earlier than usual with her superiors' permission in order to receive treatment, she also brought her work home or went to her office early in the morning to finish the work she needed to. She did so mainly because she did not think that she had changed in terms of her ability to deal with her work; however, another reason for this was that she did not like to trouble her colleagues and superiors because of her health problems. She found it 'a little bit hard' to work as she used to while receiving treatment weekly, but did not feel it was a heavy burden.

The participants who disclosed their illness when applying for a job or at work, while realising that their ability to work had changed, also did so for other people's understanding. They thought that it had become difficult for them to work as people without illness or disability generally do, or as they used to, and that it was necessary to have other people's understanding of their illness at work. When the participants wanted to have a job but found it difficult to work as people without illness or disability generally do or as they used to, they chose to apply for work for people with disabilities or disorders;

they chose to disclose their illness in the environment where it was unlikely to have negative consequences. Three participants had this type of experience. In this case, they wanted other people to understand that they were mentally ill, that they needed to continue to receive treatment, and that it was difficult for them to work in the same way as they used to, or in the same way as people without illness or disability generally do. For these participants, it was more important to keep their symptoms stable than to work as people without illness or disability usually do or to be regarded as 'normal'. Two of the participants experienced a deterioration in their symptoms when they worked while concealing their illness, and later decided to look for a job which seemed to be suitable for them. There was also a participant who disclosed his illness at work (Jyun). Jyun suffered from depression and found it impossible to work as his colleagues did and as he used to, because of his illness. He wanted his colleagues to understand that he could not work as he used to, not because he was lazy but because he was ill; he also knew that he was causing them trouble. As such, he explained to them that he had been diagnosed with depression.

Whichever approach participants adopted - concealing their illness or disclosing it - their act was a method of self-defence. They tried to protect themselves from the loss of something important to them (for example, their job or friends) or from being regarded as 'less than average', 'not normal' or negatively deviant when concealing their illness. When they disclosed their illness, they tried to protect their self-esteem by confirming that people who were close to them still accepted them or attempted to protect themselves from having worse symptoms by obtaining other people's understanding.

(ii) Disclosing the changes to almost everyone

Whereas most of the participants employed the method of selective disclosure, there were also three participants who chose indiscriminate disclosure. In the same way that limiting their disclosure to a small number of people was a form of self-defence for the other participants, for the two participants who disclosed their illness to almost everyone, this was also a form of self-defence (both of them were diagnosed with schizophrenia). Whilst they were slightly worried that responses to their disclosure might be negative, they also believed that prejudice and discrimination against people with mental illness would be reduced by revealing their illness to others and showing that they could work as people generally do, as long as they adhered to medication. One of them (Ken) stated:

Although this illness [schizophrenia] is still prejudiced against, people can recover [from schizophrenia] if they receive proper treatment and adhere to medication. I've recovered, and I seldom feel that I'm ill as long as I'm on medication. I want people to understand that people with schizophrenia are not very different to others.

The remaining participant, Gorō, who was diagnosed with schizophrenia, disclosed his illness to almost everyone because he was not reluctant to do so. He was used to describing his illness to others, as the community support centre he belonged to welcomed medical students learning psychiatry every year as trainees and he always introduced himself to them by stating that he had been diagnosed with schizophrenia. He was receiving job training at the time of interview and he was going to look for a job while disclosing his illness. Although he feared that he might be told that they could not hire people with a mental illness, his greater worry was that he would have difficulties going to hospital to receive psychiatric treatment on a working day and with having psychiatric medicines at work if he concealed his illness. He wanted to avoid these difficulties, as he believed that they would lead to a relapse of severe symptoms. Therefore, he needed other people's understanding of his illness at work, which was the reason why he was going to disclose it when applying for a job. Instead of making comparisons between himself in the past and present or between himself and other people as some other participants did, he had made a comparison between his 'imaginary' self and his actual self, and he was pleased with himself in the present. He had imagined that he would stay at home all day sleeping if he had not belonged to the centre and this would result in a deterioration of his delusion; in reality, however, he belonged to the centre and enjoyed doing some activities there and his symptoms were stable. Unlike some other participants, he probably did not hope that he would ever be the same as himself in the past, nor did he want to be regarded as 'normal' by other people. It appeared that one of the reasons for his indiscriminate disclosure was that he was content with his present self; he seemed not to be afraid of being regarded as mentally ill.

Whomever they chose to disclose their illness to (some specific people or almost everyone), disclosure of mental illness could be a problem for some of the participants because of their diagnosis (n=10). This was the case only for the participants with schizophrenia. These participants thought that they would not be very reluctant to tell

others about their diagnosis if their diagnosis was not schizophrenia but depression, and one of them had actually told others that he suffered from depression. They believed that depression had become more accepted and understood by people as the number of people diagnosed with depression increased. On the other hand, they believed that people usually did not know what schizophrenia was like, or if they did have a view, they regarded those affected by it as dangerous and violent. In contrast, none of the participants diagnosed with depression considered that their diagnosis itself mattered. For all the participants with depression, except for one, it was the fact that depression was a mental illness which made them consider whether they should disclose it to others. They were aware that people were often prejudiced against people with mental illness, regardless of their diagnosis. One participant diagnosed with depression (Yūya) was not reluctant to tell others of his condition. It seemed that this was because his colleagues and superiors had been understanding when he disclosed his illness to them. However, he still chose to whom he disclosed his illness, as he was aware that there were people who were prejudiced against mental illness. All of the participants diagnosed with depression also realised that people often had negative images of schizophrenia or they often lacked knowledge about it, and they thought that they would not have disclosed their diagnosis to others if it was schizophrenia, except for their families and those very close to them. For the participants who were diagnosed with schizophrenia and did not think that it was difficult to disclose it because of their diagnosis ($n=2$), the fact that they had a mental illness mattered most. They thought that it would be difficult to tell others that they were mentally ill, whatever their diagnosis was.

Whereas some of the participants concealed their illness because of their diagnosis, other participants did so not because of their specific diagnosis but because of their diagnosis of mental illness in general. All participants appeared to make sense of themselves through a multi-layered identity - while they were someone with a specific psychiatric diagnosis such as schizophrenia, they were also someone with a mental illness in general. Despite this however, the participants who reported that their diagnosis of mental illness in general mattered when considering disclosure of their illness appeared to be more aware of the multi-layered identity than those who did not.

6-2-6. Consequences of disclosure and concealment

Participants' choice to disclose or conceal their illness led to a range of responses from others. These responses can be classified into three patterns: (a) they were regarded and/or

treated as before and/or as someone without mental illness, (b) they were regarded as changed physically, psychologically and/or cognitively and treated as before or as someone who needed care and (c) they were regarded as changed in other aspects as well, as someone who was different from others in certain ways, or as unchanged and treated as someone who could not work or behave as people without mental illness generally do, or as someone who had problems with their personality. It should be noted, however, that these are perceived consequences, as reported by the participants. Their perceptions could be biased for a variety of reasons, including cognitive biases related to the symptoms of mental illness.

(a) As before or as people without mental illness

When the participants concealed their illness, others did not realise that the individual had been diagnosed with mental illness. This resulted in the participants being regarded and treated as before or at least as someone without mental illness. For instance, when the participants did not disclose their illness at work, they were expected to work as people without mental illness generally do or as they used to. In these cases, the participants could obtain what they wanted - being regarded and treated as someone without mental illness. However, they often had to pay a cost in order to continue to conceal their illness from others. In some cases, the participants stopped receiving psychiatric treatment, as they found it difficult to have a day off every week in order to go to hospital. This sometimes led to a deterioration in their symptoms, to the extent that it became impossible for them to continue to work.

(b) As before or as someone who needs care

As was expected by the participants who disclosed their illness to those close to them, these people understood that they suffered from mental illness and their attitudes towards the participants did not change in a negative way. In some cases, people who were close to the participants understood that they had mental illness and treated them in the same way as they did before being told about the participant's illness; their relationships remained unchanged.

With respect to family relationships, one participant (Souta) stated that his relationship with his family had changed in a negative way after he had become ill and it had taken a long time to recover a good relationship. However, it seemed that the negative change was not because of his illness but because of a violent act which he engaged in

once; this participant kicked his father's face when they had a quarrel. He was forced to be hospitalised because of his violent behaviour. Until then, his parents treated him as before. He stated that his parents had feared him after the quarrel, and they had not allowed him to return home from hospital for quite a long time. Thus, their attitudes towards him changed because of his violent behaviour. However, he stated that he had recovered a good relationship with his family and they now treated him as they used to.

Three participants stated that their relationships with their family had changed between before and after they received their psychiatric diagnosis; indeed, two of them thought that their illness had led to losing their families' trust in them. One participant, Jin, who was diagnosed with schizophrenia, stated:

Jin: Well, sure enough, trust has been lost. I'm the eldest son in my family and I have one younger sister. When I was young, I worked part-time when I was a student, saved money, travelled to South Asia, and was quite active. This activeness has come out quite a lot now but immediately after discharge from the hospital this activeness was completely gone.

Interviewer: This is due to the symptoms of the illness?

Jin: Hmm..I'm not exactly sure what to say. I've been hospitalized six times till now and the first time I was hospitalized for eight months, sure enough I think it's due to the medicines—my body movements became slow.

Interviewer: You mean, because of the side effects [of the medicines]?

Jin: Yeah, I guess so.

Jin's statement suggests that he had been trusted by his family as the eldest child and as someone who was active, but that he lost their trust because he was no longer active after hospitalisation. While he admitted that his family had lost trust in him, he stated that his family basically treated him as they used to. Another participant, Yukiko, who was diagnosed with schizophrenia, felt that the power relationship between her and her parents had changed since she had been diagnosed with schizophrenia. Yukiko had been hospitalised twice by her family against her will. Although she was grateful that her family had looked after her well when she had been experiencing severe symptoms, she felt that her parents' power over her had become stronger than before receiving the diagnosis, since her parents had her hospitalised when they thought that her illness had become worse. Yukiko, however, stated that their attitudes to her had not changed

significantly. These three participants never felt that their families were prejudiced against mental illness.

Eleven participants (of which three lived separately from their families since before the onset of their illness) stated that their relationships with their families basically remained the same after they had been diagnosed with mental illness. Of these participants, five reported that their families had not been prejudiced against mental illness, although they were not supportive or understanding either.

For some of the participants who disclosed their illness to the people who were close to them, the relationships between them changed for the better. The people who were told about the illness regarded and treated the participants as someone who needed care; these people were concerned about them and listened to and supported them when necessary. With respect to family relationships, three participants stated that their relationships with their family members had changed for the better after their disclosure. Their families were understanding and helped them in various ways. For example, one participant with schizophrenia (Mami), who lived with her family, answered the question of whether her relationships with her family members changed after she told them about her illness:

Mami: Oh, I think they have changed, have become more kind, as compared to in the past.

Interviewer: This change has been in a positive direction?

Mami: Yes.

Interviewer: Did your family members understand your conditions well?

Mami: At first it was a little tough I think, but now they understand. My symptoms were quite bad, and there were times when I just kept talking. At such times my elder sister and mother tried their best and listened to me earnestly. It seems that they often consulted one another and gave a lot of thought to what attitude to adopt towards me. They tried to treat me kindly and had an attitude of understanding about my condition.

Two other participants, who were diagnosed with depression, stated that although their relationships with their families had eventually changed for the better after they had become ill, they had experienced a difficult time until then, for it had taken their families several years to accept that they suffered from mental illness. Their families

regarded the participants not as ill but as lazy, and blamed them for not doing their duties, such as going to school or keeping a job, until they understood that they suffered from mental illness. The participants felt that they were less valued in their families because they had become unable to do routine things as they used to since they had become ill. They also thought that their family treated them as a member who was inferior to other members in the family. However, their families' attitudes had improved over several years, and the participants believed that their relationships with their families had eventually become better than before they had become ill. Reasons for the improvement in their families' attitudes included knowing that someone who was close to them was also suffering from depression, going to see a doctor with the participants, receiving an explanation about their illness, and reading books about depression. These participants stated that their families were now understanding and supported them.

Some of the participants who disclosed their illness to their colleagues and/or superiors at work stated that they had experienced positive changes ($n = 3$). Their colleagues and/or superiors understood that they had mental illness and needed treatment, and they accepted some changes which the participants wanted, such as rescheduling of work and having medicine at their office when necessary. For instance, Ruri, the participant with depression who disclosed her illness to her superiors, stated that her superiors had treated her 'very gently' and had given her the 'best support they could'.

With regards the participants who applied for work for people with disabilities or disorders ($n=3$), disclosure of their illness did not lead to negative consequences. This was as they expected. Their employers understood that they needed to continue to receive psychiatric treatment and made some arrangements so that they could work without a burden.

(c) As someone who cannot work or behave as people without mental illness generally do

Of the 20 participants, there were 15 participants who had this type of experience, namely experience of stigma. In these cases, there were two patterns: (i) the participants thought that they had changed physically, psychologically and/or cognitively, and yet people thought that some of their other aspects had also changed or thought that the participants were different to others in other aspects as well, or (ii) the participants thought that they had changed, but people regarded them as unchanged.

With regard to the first pattern, it was common for their colleagues and superiors or interviewers in a job interview thought that the participants could not or should not work as they used to or as people without mental illness generally do, because the participants had mental illness. They thought that their ability to work had also changed or they felt that they were also different in terms of their ability to work with others. Concrete examples of the participants' experience included verbal abuse, demotion and/or dismissal at work and/or rejection at job interviews. For example, one participant, Souta, who was diagnosed with schizophrenia and had continued to conceal his illness at work until he suffered a relapse, stated:

[After the relapse] Even though I didn't want to, since the caretaker at the group home said, 'Souta, it'd be best if you tell your boss about your illness', I came to feel that it'd be better to do so, so I set up a time to talk with my boss. Then, he said that people who had a mental disorder or had a disabled identification booklet would have to work part-time while being looked after by the person in charge or full-time regular employees. I'd worked very hard as a full-time regular employee, but since this happened I was demoted to the level of a part-time worker. I was no longer able to do any of the jobs I'd been assigned and that I'd been glad to have done. I thought I could do them, but they no longer let me. It was really like I was an assistant. I just ended up doing monotonous work, despite having had worked so hard. I thought that there was nothing that could be done, that the world is harsh, and worked while being dissatisfied.

As he stated, he did not think that he had changed in terms of his ability to deal with his work because of illness and that he had no problems working as other people do. He concealed his illness, for he wished to be regarded and treated as other people are. However, once he disclosed his illness, his superiors felt that he should not work as he used to or as people without mental illness generally do; they thought that he was different from others in terms of his ability to work because he had been diagnosed with mental illness. His superiors' beliefs, as he reported them, expressed prejudice against or ignorance about mental illness (at least against or about schizophrenia), and they expressed it in the form of both language and behaviour (saying that he should not work like he used to and demoting him). Souta regarded this as discrimination against him.

Some of the participants also stated that they had experienced stigma for aspects

other than ability to work. For example, Tomoko, who was diagnosed with schizophrenia, had been told by one of her friends that she (the friend) was afraid that the participant might suddenly get violent because she became schizophrenic. Although Tomoko thought that she had not changed in aspects other than her diagnosis and she behaved as before, the friend thought that Tomoko had also changed in terms of her behaviour or her nature. Tomoko felt that it was prejudice against people diagnosed with schizophrenia. The friend abandoned Tomoko soon after this and Tomoko lost contact with her. The experience was not only restricted to this friend; Tomoko reported that she had lost all of her friends since she had been diagnosed with schizophrenia. There were two other participants who stated that some of their friends had left them once they had disclosed their illness. Of these participants, one was diagnosed with depression (Yūya), whereas a second was diagnosed with schizophrenia (Akira). On the other hand, one participant (Ritsu), who was diagnosed with schizophrenia, had kept all of his friends at a distance since he became ill, as he did not want them to know that he was mentally ill. He stated that he had lost his friends because of this.

Two participants (one participant with depression and another with schizophrenia) experienced rejection of medical treatment at a general hospital, where they went because of their physical illness. The medical staff refused to treat them once the participants said that they had been diagnosed with mental illness. One of these participants (Kana), who was diagnosed with depression, guessed that they had regarded her as violent because she had been diagnosed with mental illness.

With regards the second pattern, whereby the participants thought that they had changed but people regarded them as unchanged, was true for some of the participants with depression (n=5) and one participant with schizophrenia (Sakura). With this pattern, the people to whom they disclosed their illness thought that the participants were not ill but idle, or that it was a problem with their personality. Five of these participants received this type of reaction from their family members and the remaining participant received it from his colleagues. These six participants stated that their families or colleagues lacked an understanding of mental illness. For instance, Sakiko, who was diagnosed with depression, stated:

My parents say I shouldn't take psychiatric drugs. I often tell them that my illness would worsen if I didn't take them, but they never understand. They say I'm just weak-willed and self-centred. They don't admit I'm ill.

Two of the five participants who experienced stigma within the family felt that their families not only lacked an understanding of mental illness but also that they were ashamed of their family members being regarded as mentally ill. Both of these participants had an experience in which their families were opposed to their applying for benefit because of mental illness.

Another two participants experienced stigma within their families because of their behaviour, which was caused by symptoms, rather than because of their diagnosis. One of them, Mei, who was diagnosed with depression and lived with her husband, stated:

When I told my husband that I had been diagnosed with depression, he didn't care about it at all. I explained about depression to him, but he didn't listen to me. He said it was nothing to do with him. So, he never understands how I am ill. When I feel ill and stay in bed, he blames me for not doing (domestic) chores.

After becoming ill, it was difficult for Mei to do domestic chores as she used to. However, her husband did not understand that it was difficult for her to do them because she was ill. He would blame her, not for being mentally ill, but for spending most of the day in bed. This suggests that she was influenced by her husband's ignorance about mental illness because her behaviour was affected by the symptoms of depression.

Of the five participants who were regarded as not ill by their families, two asked their families to go to see their psychiatrist with them. These participants did so because they thought that their families would understand their illness if they received explanations about depression from their doctor. In this way, the participants tried to educate their families about depression to avoid being stigmatised. As their families were not very convinced that the participants were suffering from depression when their families were given explanations about it for the first time, the participants went to see their psychiatrist with their families several times. The participants believed that this had become one of the helpful factors with regard to their families understanding depression. These participants were rather exceptional in that they tried to avoid being stigmatised by educating others; indeed, all the other participants except for them did not report that they had tried to correct others in order to avoid stigma.

The experience of stigma for these five participants was to not be regarded as ill, while they wanted their families to understand that they suffered from mental illness. In

the present study, none of the 20 participants experienced rejection from their families or lost contact with them, whilst certain US studies showed that some of the participants with mental illness had these experiences (Jenkins and Carpenter-Song, 2008; Wahl, 1999b). Furthermore, in the present study, there were no participants who expressed worry that their families might be stigmatised because of their illness (although there were two participants whose families were stigmatised because of their mental illness; the participants had not expected this). It appeared that most of the participants' major concerns related to stigma were obtaining or keeping a job and being regarded as 'not normal' by others. The participants in the present study differed from the Indian participants with depression in a study by Weiss et al. (2001); indeed, the participants in the present study did not express worries about the impact of their illness on their families, whereas the Indian participants were concerned that their illness might affect the arrangement of a relative's marriage.

The second pattern of stigma experience, whereby other people did not admit that the participants were ill, was more common within the family. However, there was one participant who had this type of experience at work. This participant, Masa, who was diagnosed with depression, disclosed his illness to his colleagues because he wanted them to understand that he was ill. However, he was repeatedly told by his colleagues that he was just lazy and he had problems with his personality. This was hard for him and he thought about committing suicide, but could not do it because he had a family to support. Since he knew that he could not work in the same way as people without mental illness generally do, it was also unrealistic to change his job; indeed, although there are jobs for people with mental illness, the salary is not sufficient to support a family. This situation left him with no choice other than to continue to work at the same company. Although feeling hurt, he thought that he had to endure his colleagues' attitudes towards him because he knew that he was causing a lot of trouble for them. Since he became ill, it had become difficult for him to deal with much work and to work quickly; his colleagues needed to do the work which was supposed to be his.

Although most of the 15 participants experienced stigma as a result of their own disclosure, there was one participant (Mika) who experienced it because other people disclosed her illness. She had been diagnosed with depression and did not disclose it except to her family and friends; despite this however, neighbours in her home town, which was not Tokyo, knew that she had been diagnosed as mentally ill in Tokyo. The rumour spread quickly, as the town is small. When back in her home town, she heard that

neighbours called her 'mad' and she felt prejudiced against. Furthermore, she stated that her family had also been stigmatised by the neighbours and her relatives because of her psychiatric diagnosis:

My illness and hospitalisation [because of mental illness] seems to have become a laughing stock among my relatives and neighbours in my hometown. It's a small town and I knew that someday this would happen but even my family suffers with prejudice and I wonder why even my family has to go through abuse like that. My house is viewed as a house in which a lunatic lives and they call us a mad family. Perhaps my family will forever come to be labelled as a family that gave birth to a lunatic.

This is a clear example of what Goffman (1963) calls 'courtesy stigma', which means that people are stigmatised because of their relationships with those with stigma. In Mika's case, it seemed that her relatives and neighbours regarded mental illness as hereditary; they called her whole family 'mad' when one member was diagnosed with mental illness. Her statement that they might continue to be labelled forever also suggests that these relatives and neighbours view mental illness as hereditary. There was another participant (Jin) whose family also experienced courtesy stigma. Jin had a diagnosis of schizophrenia. According to him, his relatives stopped inviting all of his family members to their wedding parties once he had been diagnosed with schizophrenia. In this case, it seemed that the sense of shame in his relatives, together with prejudice, was an important reason for their reaction.

Among the participants who experienced stigma, two stated that these experiences had made them aware of the strong negative views on mental illness that exist in society, and that they had become more careful about managing information pertaining to their illness. This suggests that experiencing stigma can lead to realisations about stigma against mental illness and to more careful management. For instance, Tomoko, who was diagnosed with schizophrenia, sensed that people had bad images of mental illness even before disclosing her illness. At the same time, however, she thought that her illness would not affect her relationships with her friends or employment, as she had not changed in terms of her personality or ability to work because of her illness. However, other people's reactions were much more negative than she had expected. She was refused work in job interviews, where she disclosed her illness, and all her friends left her after

she had been diagnosed with schizophrenia. As Tomoko had not expected such cruel treatments, she felt devastated and decided not to disclose her illness even to those close to her. She also stopped disclosing her illness in job interviews, and was working while hiding her illness at the time of her interview.

Although the present study is focussed on the stigmatised rather than the stigmatisers, it seemed that the people stigmatised the participants as a cognitive and/or emotional reaction. Of particular note here is the situation where a person said that a participant would act violently because she/he had been diagnosed with mental illness and the person left the participant. Indeed, this can be seen as a cognitive reaction - this person had little knowledge about mental illness and was prejudiced against it. However, it also is possible to interpret this as an emotional reaction, since the person left the participant probably because he/she feared becoming a victim of the participant's violence.

6-2-7. Anticipated stigma while no stigma experience

There were five participants who reported that they had never experienced stigma. All of them were diagnosed with schizophrenia. They did not experience stigma within the family, as their families were understanding or at least did not exhibit prejudicial attitudes towards the participants. They also had no experience of stigma in other areas, such as the workplace. These participants thought that they had never experienced stigma because of the good environment around them. Two of them were attending a community activity support centre for people with mental illness, where they were receiving job training; the remaining three participants had a job for people with illness or disability. The people whom the five participants met on a daily basis, including other members at the centre, the staff, colleagues and superiors at work, knew that they had been diagnosed with schizophrenia and were understanding.

However, although having never experienced stigma, all of the five participants anticipated that they would be stigmatised if they disclosed their illness to those who knew little about mental illness, particularly in a job interview. Thus, they were aware that people with a diagnosis of mental illness were likely to be stigmatised. One of these participants (Mami) made a statement about her perception of stigma against people with mental illness:

There's a term called menhera [one who is afflicted by mental illness], isn't it? This term menhera is used in various places nowadays and it refers to one who is afflicted by mental illness. This may not be an equivalent but is certainly close to it, and those who are mentally ill are called menhera. One of my very good friends refer to those who are mentally ill as irritating on Twitter. I haven't told this friend that I have a mental disorder. So, every time I see her saying that, I think she can do that probably because she doesn't know that I have mental illness, and if she can still say that even after she knew I am one of them, then I think that she meant to include me. When I see things like this said that those who are mentally ill are irritating, I feel that even though they are friends they are saying such mean things. In the world of Internet, those who are afflicted with mental illness are bullied, or I mean I feel there are a lot of negative expressions that are used. So that's why when I'm invited and go out with my friends to a drinking party, I would absolutely not reveal that I have a mental disorder. It's because mental illness seems to give a bad impression in general.

Mami feared that her friends might leave her once she disclosed her illness. Anticipation of stigma was seen among all the 20 participants in the present study, regardless of their stigma experience. This signifies that stigma affected the participants in the form of anticipation or in the form of both anticipation and experience.

6-2-8. Comparison between the participants with schizophrenia and those with depression: receiving diagnosis, stigma not related to mental illness and types of experienced stigma

There were some similarities between the perception, management and experience of stigma among the participants with schizophrenia and those of the participants with depression - for instance, both of them were aware of the negative images of mental illness, anticipated stigma, and often concealed their diagnosis, while some experienced stigma at work, within the family and/or in social relationships. Despite this however, there were also differences. In this section, some comparisons between the two groups will be made, focussing upon the differences.

(1) Receiving and accepting diagnosis

Whilst all of the eight participants with depression went to hospital of their own free will,

the majority of the participants with schizophrenia (66% or 8/12) were taken to hospital by other people for the initial consultation. Among the participants with depression, four of the eight stated that they had self-diagnosed their depression before seeing a doctor. These four participants thought that they were probably suffering from depression because their changes (or symptoms) were the same as the symptoms of depression as they understood them. In this vein, receiving a psychiatric diagnosis probably meant a confirmation of the change of self-perception for them. The remaining four participants with depression were not sure what diagnosis they would be given, although all of them appeared not to have been puzzled by the diagnosis they received. They often heard the word 'depression' in the media and had some images of what it is like. Although one of them (Lisa) said that she was slightly surprised when receiving a diagnosis of depression, as she had thought that depression would be more serious than the symptoms which she was experiencing, it was a relief for her to have a diagnosis. She stated, 'if you have a diagnosis, it's clear how to treat it'. She was also relieved that her doctor had said that her illness was one of the 'commonest ones' and that it was 'curable'.

On the other hand, among the participants with schizophrenia who went to hospital of their own free will, all but one did not expect a diagnosis of schizophrenia. Three participants who were told their diagnosis at their initial consultation were puzzled or shocked by the diagnosis. One of these participants, Sakura, who had expected a diagnosis of depression, stated:

I didn't think that my illness was something awful like schizophrenia. I knew the name [schizophrenia], but I couldn't get my head around it when it was suddenly said to me. Depression happens to one in five people but schizophrenia is something that usually happens to one in a hundred people. So I guess it was hard for me to think that I had this rare disease [schizophrenia], which only happens to one in a hundred people. [After receiving the diagnosis] I was happy that I clearly knew what my disease was, but at the same time I was also very sad. I actually might not have wanted to know [the name of the condition I was diagnosed with].

There was one participant (Yukiko) who had expected to be given a diagnosis of schizophrenia, as her sister had been diagnosed with the same condition, and thus she knew the symptoms. This participant was also shocked when being told her diagnosis. In

the same way as those who were told their diagnosis at their initial visit to hospital, the participants who learnt their diagnosis later were also puzzled and shocked by their diagnosis of schizophrenia. One participant (Souta) was puzzled because he knew nothing about schizophrenia, whereas other participants were shocked because they regarded schizophrenia as a serious illness or they thought that schizophrenia was related to violence. One of the participants, Tooru, who was given his diagnosis later, told of how he felt when being told his diagnosis:

I felt like I wouldn't be able to lead a normal life any more. I got the feeling that all of my hopes for the future had disappeared. Because I became schizophrenic, I thought I probably wouldn't be able to work like a normal person and that I probably couldn't keep my job.

None of the participants diagnosed with schizophrenia could accept their diagnosis at first, which is in contrast with the reactions of the participants with depression. The process of accepting a diagnosis of schizophrenia was similar across the participants who went to hospital of their own free will and those who were taken to hospital by others; with this said however, the duration needed was different between the two groups. Whilst the former participants accepted their diagnosis relatively quickly (range from several months to one year), the latter participants took several years. During the process of accepting their diagnosis, most of the participants (both groups) collected information about schizophrenia and studied the illness and treatment. It was also important for them to realise the efficacy of psychiatric drugs to accept that they were suffering from mental illness.

Furthermore, for most of the participants with schizophrenia, their specific diagnosis mattered when thinking about disclosure of their illness, whilst all of the participants with depression thought that their diagnosis of mental illness mattered more than the specific diagnosis. One of the reasons why the diagnosis of schizophrenia mattered to the participants diagnosed with the condition was that they had known that schizophrenia had a bad image among lay people. Two participants with schizophrenia also stated that they usually concealed their diagnosis because people would not understand what schizophrenia is like.

(2) Another stigma

The 12 participants with schizophrenia found it difficult or were unable to work or study, particularly when they were experiencing severe symptoms. Except for those who did not have a job and who were not students, the participants had to resign from their job or withdraw from college. Until their symptoms became stable, most of them had stayed at home with their families while receiving treatment as outpatients or had stayed in hospital. Five participants stated that they had been ‘shut-in’ or *hikikomori* in Japanese for a while (range from a few months to nine years) after they had become ill.

The word *hikikomori* is often used in Japan, probably as a reflection of the large number of people who are shut-in. In 2010, the government surveyed a nationally representative sample of adults aged between 15 and 39 (response rate = 66%) (Cabinet Office, 2010). They concluded that respondents were ‘hikikomori in a narrow sense’ when respondents reported:

- They do go out but only in their neighbourhood
or
- They go out of their room but do not go outside of their house
or
- They seldom go out of their room
and
- They have been like this for more than six months.

The government also included respondents in their definition of ‘semi-shut-in (or semi-hikikomori)’ when respondents reported:

- They go out only when they have to do something related to their hobbies, for which they need to go out
and
- They have been like this for more than six months.

In terms of their definitions of ‘hikikomori’, the government excluded respondents who reported that they had been like this because of schizophrenia, physical illness or pregnancy, or because they had been looking after home and family or they worked from home. The estimated number of people who were ‘hikikomori in a narrow sense’ stood at 240,000, whilst that of the people who were ‘semi-hikikomori’ was 460,000. The total

number of 700,000 is equivalent to 2% of the total population of those aged between 15 and 39 in Japan. Of the respondents who met the definition of 'hikikomori' or 'semi-hikikomori', 66% were men. The most common reasons for their having become shut-in included illness (24%; other than schizophrenia and physical illness) and 'I could not adjust myself to the workplace' (24%).

With regard to the participants in this study, two of them became shut-in because of their symptoms, whilst the remaining three did so not because of their symptoms but because they worried about what others would think of them if they strolled about during the day. All of these three participants were men, who had been in their mid-twenties or early thirties when they had been shut-in. One of these participants (Ritsu) explained how he became shut-in and how he was leading life during this period:

During the day, children and those with small children are outside, and I thought that seeing a 30-year old guy like me walking idly they would surely think, what kind of a person is he, not even working, so I decided not go out. For more than nine years I was rather in a state of *hikikomori*. I didn't go either to the day care or the workplace. I would just go to the hospital once a week on Thursdays, and bought food for lunch and come right back. My mother then prepared dinner for me. I tried to avoid going out during the day, I mean, I just didn't go out.

Like Ritsu, two other participants were also worried what other people would think of them. What they feared was not being regarded as mentally ill but being regarded as someone who does not do their social duty. They appeared to have felt the pressure that men should work, and this pressure was their major reason for having become shut-in. By not going out, these participants tried to avoid the stigma related to social responsibility. In other words, they anticipated another stigma because of their situation in addition to the stigma of mental illness.

It seemed to be stressful for some of the participants' parents to see their adult children staying at home, doing nothing. Two of the three participants stated that their parents complained about their not having a job, which developed into a heated quarrel between them. One of the participants (Ritsu) felt isolated in his home because of this, and he decided to hospitalise himself, since he had no other place to go. Another participant (Souta), finding himself in a state of irritation, kicked his father's face during their quarrel. He was forced to be hospitalised because of this. This participant stated that

it had taken a long time to recover a good relationship with his parents.

Among the participants with depression, there was no one who became shut-in. For these eight participants, their illness appeared to have had less influence on their social lives than the participants with schizophrenia. In fact, although one participant (Kazuyo) had to resign from her job because of her illness, other participants did not have such a significant change in their social status (e.g. employment status) because of their illness. Unlike the participants with schizophrenia, most of those with depression continued to lead a social life even after the onset of illness. Although Kazuyo was unemployed and usually stayed at home at the time of her interview, she did not regard herself as shut-in. She went out freely, and did not care what other people would think of her when she was out during the day. This contrasts with the view of the three participants with schizophrenia who worried that other people would wonder about them if they were out during the day. It seemed that there was a gender difference here; while the three male participants appeared to feel the pressure that men should work, the female participant did not appear to feel such a pressure that women should work. In light of this, it seemed unlikely that she would become shut-in in order to avoid another stigma related to social responsibility as the three participants did.

(3) Types of stigma they experienced

When making a comparison between the stigma experience of the participants with schizophrenia and that of the participants with depression, whilst the former tended to experience loss of social status, including demotion and dismissal at work, the latter tended to be regarded as not ill or as someone who has problems with his/her personality. This suggests that the participants with schizophrenia were more likely to be regarded as seriously ill or different from other people, whereas the participants with depression were more likely to be regarded as not ill. One of the possible reasons for the stigma experience among the participants with schizophrenia is the negative and distorted images of schizophrenia. Other people probably thought that people with schizophrenia would not be able to work as other people do. This can also be regarded as ignorance about people with schizophrenia. On the other hand, the participants with depression were more likely to be regarded as not ill, probably because the behaviour caused by the symptoms (for example, doing their job slowly or staying in bed all day) looked like laziness rather than something coming from illness. This suggests that people around the participants knew little about the symptoms of depression. Another possible reason is that the people around

the participants did not want to admit that they were mentally ill, particularly when the participants were their family members. In this case, it seemed that the sense of shame, in addition to ignorance about and prejudice against mental illness, was an important factor.

6-3. Summary

This chapter has presented the findings of the analysis of magazine articles and the interview data. The analysis of story themes of magazine articles revealed that (1) the readers had perceived distorted negative images of mental illness in society, (2) they had often concealed their illness from others, whilst a few readers had disclosed it and tried to educate people in order to avoid stigma, (3) concealment had often led to a burden such as anxiety, (4) they had often felt other people's lack of understanding about mental illness, particularly within the family, (5) they had lost a part of their lives including relationships with others and their job, (6) they had been treated as 'mad' and/or inferior to others, (7) they had been rejected on some occasions, including an opportunity to work, and (8) there had been few qualitative changes in perceived and experienced stigma over time, although the management of stigma had been changing among some of the readership, with legal changes regarding employment of people with mental illness coming into force in 2006. With respect to elements (how stories are told), the major findings were that the readers had often expressed their experience or perception or the burden caused by concealment as emotional pain in order to share it with other readers. In contrast, some readers had tried to tell their fellow sufferers that not all people had been cruel and there had been people who were understanding of their illness. Indeed, they talked of both the stigmatising and favourable reactions from others. On the other hand, the overall tone of the interview participants was different from the tones of the articles in the magazines, as the interviewees did not focus on their emotional pain.

In the analysis of interview data, it was revealed that the participants' self-perception had changed because of psychiatric diagnosis and symptoms of mental illness, and they had perceived, managed and experienced stigma in the process of living with the self that has changed. Once the participants admitted that they were mentally ill, they faced a problem regarding the management of information about their illness. Whilst the participants believed that people with mental illness were now less stigmatised, they were also aware that images of mental illness in society remained largely negative, which often led to concealment of their illness. Although there were a few participants who coped

with stigma by educating others, they were the minority, as almost all the participants chose to conceal their illness as a method of management.

When participants feared that they would lose something important to them and wanted to be regarded and treated as ‘normal’, they concealed their illness, although some of them felt the burden of concealment. The participants disclosed their illness when they found it difficult to conceal it, or when they wanted others to understand that they had changed physically, psychologically and/or cognitively. For the majority of the participants, diagnosis (particularly diagnosis of schizophrenia) mattered when disclosing their illness, whereas some participants believed that it was difficult to disclose mental illness, regardless of the diagnosis. There were also a few participants who did not hide their illness and some believed that this would lead to a reduction of the stigma against mental illness in society. Whichever approach they chose (concealment or disclosure), their act was a form of self-defence. Their concealment or disclosure led to a range of reactions from others, and those who disclosed their illness to people who were close to them generally received positive reactions; they understood that the participants were ill and treated them as before or as someone who needed care. However, there were also participants who experienced stigma. Of these participants, some were regarded not as ill but as lazy, whilst other participants were regarded as if they were different from others and were rejected or discriminated against. Although there were a few participants who never experienced stigma, all the participants, including those with no experience of stigma, anticipated stigma.

Whilst there were some similarities in the perception and management of stigma between the participants with depression and those with schizophrenia, experiences differed, particularly in terms of receiving and accepting the diagnosis and the types of stigma between those with depression and those with schizophrenia.

An interesting discovery was made whilst examining the findings of the interview study and the analysis of magazine articles in relation to the findings of the analysis of newspaper articles which were presented in Chapter Five. Indeed, whilst the results of the analysis of newspaper articles suggest that views on mental illness have been changing, those of the analysis of magazine articles show that there have been few qualitative changes in the perception and experience of stigma among people with mental illness over time. This may indicate that stigma against mental illness still prevails, while social attitudes towards mental illness have been gradually changing.

When comparing the findings of the analysis of newspaper articles and those of

the interviews, one can see that some interview participants' perceptions of images of mental illness in society reflect the changes in reporting of mental illness in newspapers. As some participants believed, the reporting of mental illness, and particularly of depression, was found to have generally changed to be less stigmatising, with the number of articles related to dangerousness of mental illness decreasing. On the other hand, one can also say that the perceptions of the readers and interview participants agree with the findings of the newspaper analysis in another way; indeed, both the readers and participants were aware of negative images of mental illness in society, whilst the newspaper analysis found that the majority of articles were related to dangerousness of mental illness throughout the sample period.

During the interview study, the majority of the participants with schizophrenia reported that they found it difficult to disclose their illness because of the diagnosis, whilst participants with depression stated that their diagnosis of mental illness, rather than diagnosis of depression, mattered when disclosing their illness. All the participants with depression also stated that they would not disclose their diagnosis if it was schizophrenia rather than depression, and some of the participants with schizophrenia reported that it would be easier to disclose their diagnosis if it was depression. These findings suggest that their perception of the images of schizophrenia and depression in society mirrors the portrayal of these illnesses in newspapers. As the analysis of newspaper articles revealed, articles featuring schizophrenia were often related to dangerousness, particularly to violent crime, and this trend showed little change over time; in contrast, the proportion of articles related to dangerousness decreased over time in the reporting of depression. The participants' awareness of images of schizophrenia and depression also agrees with the findings of the surveys on social attitudes towards mental illness in Japan. As we saw in Chapter Two, some Japanese studies revealed that respondents had shown more stigmatising attitudes or greater hope for social distance to persons with schizophrenia than those with depression.

The next chapter discusses the findings presented in this chapter and examines the implications, limitations and significance of the present study.

CHAPTER SEVEN: DISCUSSION OF THE FINDINGS OF THE MAGAZINE ARTICLE ANALYSIS AND INTERVIEWS

This chapter discusses the findings of the analyses of magazine articles and interview data, comparing them with the findings of prior studies and placing them within theoretical contexts. This chapter also examines the implications of the present study for strategies aimed at reducing stigma against mental illness and the limitations and significance of the study.

7-1. Comparison with prior studies

The present study examined the perception, management and experience of stigma among people with mental illness in Japan. This section discusses the findings of the present study (magazine article analysis and interview study) in comparison with those of prior studies. As we saw in Chapter Three, there have been few studies concerning the perception, management and experience of stigma among people with mental illness in Japan. Therefore, in most cases, this section compares the findings of the present study with those of prior studies conducted in other countries.

7-1-1. Perception of stigma

As we saw in the review of previous studies in Chapter Three, quite a few quantitative studies have shown that people with mental illness often perceive that most people would devalue, discriminate against or reject those affected. Although it is not appropriate to compare these findings directly with those of the present study because of the methodological differences, in a broad sense, one of the findings of the interview study, namely that all the participants were aware of the negative images of mental illness in society, agree with the findings of those quantitative studies. This suggests a similarity in stigma perception between people with mental illness in Japan and those in other countries. This may not be surprising, firstly because, as shown in Chapter Five, Japanese newspapers share some similarities with those in other countries in terms of their portrayal of mental illness, such as a high proportion of articles related to dangerousness and negative depictions of schizophrenia. Secondly, the perception of people with mental illness when it comes to the images of their illness in society can be influenced by the descriptions in the media.

As shown in Chapter Three, some qualitative studies found that the perception

of stigma could vary between cultures. In most of these studies, participants were those who were experiencing several different cultures in their everyday life, such as Asian-British or Black people living in the US. On the other hand, most of the interview participants in the present study seemed not to think that they were experiencing different cultures on a daily basis, and did not compare their perception, management and experience of stigma between different cultures. There were only two participants who did compare their perception, management and experience of stigma between different cultures, and they made comparisons between their home town and Tokyo. In their view, Tokyo was different from small towns in that mental illness, particularly depression, was not so stigmatised. Like the interview participants, the magazine readers also appeared not to compare their perception, management and experience of stigma between different cultures; there were no articles where they made such a comparison.

Both during the interview study and magazine article analysis, people with mental illness seemed to be most concerned about keeping or obtaining a job and being regarded as 'not normal'. Concerns about work among people with mental illness have been recorded both in the quantitative and qualitative literature, including various countries (US: Jenkins and Carpenter-Song, 2008; 2009; 27 countries, mainly from Europe: Thornicroft et al., 2009; Ireland: Lakeman et al., 2012). In this vein, the perception and anticipation of stigma among the readers and interview participants in the present study were similar to those among people with mental illness in other countries. Concern about being regarded as 'not normal' will be discussed below, in the sub-section 'Management of stigma'.

The perception and anticipation of stigma among the readers and interview participants in the present study differed from those of Indian participants with depression in the study by Weiss (2004). Indeed, in the latter, participants expressed great concern about the influence of their illness on the arrangement of their own marriage or a relative's marriage. Worries about the influence of their illness on their family's reputation and the marriage prospects of family members were also found among South Asian, black African and black Caribbean people living in the UK (Shefer et al., 2012). The participants and readers in the present study, on the other hand, seemed to regard stigma as a more personal problem rather than a problem which can also affect people around them. With this said however, two interview participants did experience courtesy stigma because of their illness, which suggests that mental illness can also affect people around those with the illness in Japan.

In the present study, interview participants with schizophrenia described the shock or confusion at receiving or becoming aware of their diagnosis. On the other hand, for some participants with depression, receiving the diagnosis was confirmation of a change of self-perception, as they had self-diagnosed their symptoms. None of the participants with depression, including those who had been uncertain what diagnosis they would be given, stated that they had been shocked or confused by the diagnosis. This difference may stem from the images of each illness in Japan. As we saw in Chapter Five, schizophrenia is often reported in relation to dangerousness and this trend has seen little change over time; conversely, depression is now being reported in a less stigmatising way in newspaper coverage. The difference in reaction and feeling towards their diagnosis between those with schizophrenia and those with depression has been described in a British study (Dinos et al., 2004), which produced similar findings to those of the present study. In Dinos et al.'s study, while those with depression tended to feel relieved when receiving their diagnosis, most of the participants with schizophrenia felt stigmatised following their diagnosis.

According to the interview study by Pitt et al. (2009), which explored the impact of psychiatric diagnosis on people with mental illness ($n = 8$; diagnoses included bipolar disorder, schizoaffective disorder, schizophrenia and personality disorder) in the UK, receiving a psychiatric diagnosis had both positive and negative aspects for the participants. Whilst it meant a means of access to treatment or provided them with a helpful framework with which to understand their problems, it also worked as a negative labelling. Furthermore, regardless of whether the diagnosis was experienced positively or negatively, psychiatric diagnosis was a potential cause of social exclusion for all the participants. This finding regarding the positive side of receiving a psychiatric diagnosis can be applicable to some participants in the present study, and particularly those with schizophrenia. For them, receiving or becoming aware of their diagnosis led to studying their illness, through which they came to understand their illness better. The finding by Pitt et al. (2009) that psychiatric diagnosis is a potential cause of social exclusion also agrees with the perception of participants in the present study, as they anticipated that they might lose a job, friends, and so on, if they disclosed their illness. However, there was a difference between those with schizophrenia and those with depression in terms of whether their illness actually affected their social lives. While all the participants with schizophrenia had experienced the influence of their illness on their social life, such as loss of job, participants with depression experienced this type of influence less frequently.

7-1-2. Management of stigma

The present study's finding that many of the readers and interview participants chose selective disclosure in order to avoid stigma agrees, in a general sense, with the findings of the existing studies we saw in Chapter Three. Both in the interview study and magazine analysis, selective disclosure was the most frequently used method for coping with stigma, whilst some people tried to avoid stigma by educating others about mental illness. With respect to selective disclosure, Chen, Lai and Yang (2013) revealed that decisions on disclosing mental illness diagnosis among Chinese psychiatric inpatients living in the US depended upon their trust in the people who were close to them. This was true for most of the interview participants in the present study; they chose to disclose their diagnosis to those who were close to them and who would understand that they were ill, except for the cases where they had to disclose it.

In the present study, most participants wanted to avoid being regarded as not 'normal'. They seemed to care how others would view them, and this often led to concealment of their illness. Concern about other people's opinions and reactions and a desire to pass publicly for 'normal' among people with mental illness have been described in the previous literature (UK; Forrester-Jones and Barnes, 2008; US; Jenkins and Carpenter-Song, 2009). Indeed, these views are shared between Japanese people and people in other countries. However, a cultural factor might have affected the concern and desire of Japanese participants. Researchers have argued that Japanese individuals think that their worth lies in their relationships with others, their interdependency and trust between them, rather than in themselves (Kimura, 1972; Hamaguchi, 1988). Sakuta (2001) points out that families in Japan usually lack their own strong sense of values, and therefore are likely to be influenced by society's sense of values. Abe (1995) argues that, whilst a society can be regarded as a formation of individuals who are secured by their dignity in Western Europe, an individual's dignity is not fully respected in Japan, and '*seken*' (others in general) is the basic norms of everyday life for individuals. In Japan, people say, for example, 'we need to apologise because we disturbed *seken*'. Indeed, this clearly shows that *seken* is one of the authorities in Japan. This argument may help to understand why interview participants in the present study felt concern about how others would view them. In a culture where other people's views are norms, it would be more difficult not to care about their opinions and reactions than in a culture where this does not hold. It is true that some participants in the present study thought that their health

mattered more than other people's opinions and chose to have a job for people with disabilities or disorders, and this type of stigma management is similar to that of American participants in the study by Alvidrez, Snowden and Kaiser (2008). However, these participants represented the minority in the present study.

Concern about other people's views was also found in the management of stigma related to social responsibility among some interview participants. We saw in the previous chapter that some interview participants became *hikikomori* or shut-in because they were concerned how others would view them. According to Ishikawa (2007), the word *hikikomori* became widely known in Japan in 1999, when three criminal incidents were reported; all of the suspects had been *hikikomori*. It is unknown whether or not *hikikomori* is a phenomenon unique to Japan. In the UK, for instance, there were 922,000 people aged 16-24 who were NEET (not in education, employment or training) during the second quarter of 2015, which is equivalent to 13% of those in this age group. Despite this, half (46%) of those who were NEET were looking for work and were available for work (Office for National Statistics, 2015), thus suggesting that it is unlikely they were shut-in. It is unknown whether the remaining 'economically inactive' people were shut-in.

The fact that some participants became *hikikomori* because they did not want to be regarded as someone who does not have social responsibility seems to reflect the cultural factor mentioned above; others' views affected them, as they are the norms in Japan.

7-1-3. Experienced stigma

The present study defined stigma as comprising three components: ignorance, prejudice and discrimination. The readers' and interview participants' experiences in relation to each component will be summarised below, followed by a discussion of the areas where they were stigmatised.

Ignorance

Ignorance about mental illness was often expressed as a 'lack of understanding' by the magazine readers and interview participants. There were many readers who wrote that their families lacked an understanding of mental illness, while some interview participants also stated this. The readers and interview participants shared the experience whereby they had been regarded not as ill but as lazy, weak, or as someone with personality problems by other people. In the interviews, some participants mentioned that

lay people now knew about depression but did not understand schizophrenia, which was one of the reasons for their reluctance to disclose a diagnosis of schizophrenia.

Prejudice

Prejudice experienced by the readers and interview participants was often associated with negative and distorted images of mental illness. Their experiences included being directly or indirectly told that they must be violent, mad and/or inferior to others or being shown such attitudes by others.

Discrimination

There were many readers who had been treated differently in a negative way and most of the interview participants also had such an experience. The concrete examples of discrimination included demotion or dismissal at work, rejection in a job interview, rejection of physical treatment at hospital, rejection from friends, and so on.

Areas where people with mental illness experienced stigma

In this section, the experience of the readers and interview participants will be discussed in relation to four areas: employment, personal relationships, health care and business and finance. These four were found to be the major areas where people with mental illness experienced discrimination in the Ireland-based qualitative study by Lakeman et al. (n = 30; 2012).

Employment

This was the most common area where the readers and interview participants had experienced stigma. They experienced stigma most frequently in the form of discrimination such as demotion, dismissal or rejection in a job interview, whilst some people had been told prejudicial things at work or in a job interview. Concealment of illness in the workplace or in a job interview was common, as they anticipated stigma even when they had never experienced it. It was difficult for some people to work whilst concealing illness and they suffered a psychological and/or physical burden, which sometimes led to a relapse of severe symptoms.

Prior studies have shown that people with mental illness often experience stigma in the area of employment. Quantitative surveys in Poland (Świtaj et al., 2012), England (Gabbidon et al., 2014), New Zealand (Peterson et al., 2006), and the United States

(Baldwin and Marcus, 2006) found that 20-31% reported that they had experienced stigma either in the workplace or when attempting to find a job. International studies including 27 countries also showed that 29% experienced stigma either when attempting to keep or find a job (Thornicroft et al., 2009). Furthermore, qualitative studies have also shown that employment is one of the most common areas where people with mental illness experience stigma (González-Torres et al., 2007; Jenkins and Carpenter-Song, 2009; Schulze and Angermeyer, 2003). Concrete examples of stigma experience in these quantitative and qualitative studies include dismissal, rejection in a job interview, difficulty in returning to their job after psychiatric hospitalisation, refusal of promotion, and pejorative stereotyping by colleagues and/or superiors. These examples all fit with the experience of the readers and interview participants in the present study, thus suggesting that practices of stigma in employment are similar among different cultures.

Personal relationships

Personal relationships here include family, friends, acquaintances and intimate relationships. Like employment, personal relationships were also one of the most common areas where the readers and interview participants experienced stigma. Loss of friends and being mocked or shunned by their relatives and/or neighbours were reported both by the readers and interview participants, whilst only the readers mentioned stigma experience in intimate relationships. Personal relationships were one of the areas where people with mental illness often experienced stigma in prior studies as well (Hansson, Stjernswärd and Svensson, 2013; Elkington et al., 2012).

It was notable that many readers had experienced stigma within the family, whilst some interview participants stated that their relationships with family had changed for the better after they had been diagnosed with mental illness. When the readers and interview participants experienced stigma within the family, the experience was often related to ignorance about mental illness; their families had little knowledge of their illness and did not understand it. Families' lack of understanding has been mentioned in the existing studies as well, both quantitative and qualitative (Karidi et al., 2010; Moses, 2010; Wang, 2011).

Experiences of the families of people with mental illness have received much attention in research, and there is now a great deal of literature on this topic. Studies have shown that, for instance, families looking after people with mental illness or both mental and somatic illness reported significantly higher levels of subjective burden than those

looking after people with just somatic illness (the Netherland; Hastrup, Van Den Berg and Gyrd-Hansen, 2011). These studies also reported that families' perception of 'stigma by association' leads to their psychological distress (the Netherland; van der Sanden et al., 2013), and that families of people with mental illness had had significantly lower scores of quality of life than other parts of the population (Hong Kong; Wong et al., 2012). Finally, previous investigations found that families had gained rewards such as growth in character by looking after their ill relatives (Germany; Bauer et al., 2012). There are also some studies which have focussed on the experience of families of people with mental illness in Japan. This research has found that, for example, lower levels of physical and mental health of families were correlated with severe or unstable symptoms of their ill relatives (Tanaka and Yanase, 2009); families also vacillated between expectations for their ill relatives and anxiety about the future regardless of elapsed years (Nakatsubo, 2010). Finally, family acceptance and stress coping behaviour indirectly determined families' negative attitudes towards their ill relatives via distress in daily life (Okamoto et al., 2008). The findings of studies both in Japan and in other countries suggest that mental illness can affect not only the sufferers but also their families in terms of their psychological health, quality of life, stigma and so on.

The present study found that the relationships with family members had changed for the better for some interview participants. Their families tried to understand their illness by collecting information and learning about the illness; they also helped the participants in various ways. For these participants, their families were a great support in dealing with the symptoms and other difficulties related to their illness. Half of the interview participants reported that their relationships with their families had basically been the same before and after they had disclosed their illness, although five of these participants had experienced stigma within the family. Experience of stigma within the family was frequently found among the magazine readers. This may be because two of the three magazines were for the families of people with mental illness; it may also be the case that the readers thought that, by reading the articles, families, if not their own families, might understand that people with mental illness often suffered from their families' lack of understanding.

Within the family, the readers and interview participants often experienced stigma in the form of ignorance. As some interview participants found that education was one of the effective ways to obtain their families' understanding of their illness, this may represent a good approach to educating families in order to reduce the possibility of

people with mental illness experiencing stigma within the family. However, it appeared that families' sense of shame also led to denial of mental illness. This suggests that it is necessary to adopt an approach which is capable of reducing the sense of shame as well. Although it was common for the participants with depression to be regarded as not ill in the present study, González-Torres et al. (2007) found that many of their participants with schizophrenia had also experienced this type of stigma. This suggests that people with mental illness can be misunderstood as not ill, regardless of their diagnosis.

Whilst there were readers and interview participants who had experienced stigma within the family, rejection and avoidance from families were not reported. This may be explained by two cultural factors: (1) families' awareness of self-care and the expectations of the social role of self-care in families and (2) the 'ie' system, which was established in 1898 and abolished in 1947. According to Munakata (1984), in Japan, families' awareness of caring for their members is high, and they are socially expected to look after family members. Thus, families make a great effort to care of their ill relatives and share responsibility. Moreover, in the 'ie' system, where the first-born son succeeds the household and is responsible for all other members, a relative who is ill is under the responsibility of the head of the family and, hence, is looked after within the family. Although the ie system was abolished, the findings of the present study suggest that the culture still remains and therefore the family is unlikely to reject its members and lose contact with them in Japan, even if they are ill.

Health care

This was the area where only a few readers and interview participants reported experience of stigma. When compared to the areas of employment and personal relationships, it appeared that the area of health care was not the major issue in terms of their stigma experience. In fact, two interview participants even stated that they had enjoyed life in hospital; the staff were kind, they were protected from the outside world and they also made some friends there.

In contrast with the findings of the present study, prior studies conducted in other countries, including European countries, the United States and Australia, have shown that health care is one of the most common areas where people with mental illness reported experience of stigma (Buizza et al., 2007; Mestdagh and Hansen, 2014; Wahl, 1999b). In terms of the origin of the difference between this finding of the present study and the findings of the existing studies, there is a great deal of uncertainty. It may well be the case

that Japanese people with mental illness experience stigma in the clinical setting less frequently than those with mental illness in other countries do. However, there is also the possibility that the readers and interview participants did not focus upon their experience with mental or general health professionals, even if they had been stigmatised by these professionals, as they found stigma experience in other areas to be more intense.

Business and finance

The readers and interview participants in the present study rarely reported experience of stigma in this area, although there were some readers who reported that they had been rejected when applying for insurance or when trying to rent a room because of their illness. This finding may mean that people with mental illness in Japan usually do not face difficulties in this area, or it could indicate that many of those who have a job are not business owners but employees. It may also mean that many people with mental illness live with their families, and therefore it is unlikely for them to have problems with housing in Japan. In a multisite survey involving 27 countries, 14% of those with schizophrenia reported that they had been negatively discriminated against in housing, while 11% reported that they had been positively discriminated against in this area (Thornicroft et al., 2009). Positive discrimination included having been able to obtain housing or special loans because of their illness (Rose et al., 2011).

7-2. Theoretical consideration

The following sub-sections discuss the findings of the present study, placing them within the existing theoretical concepts: illness-identity work, labelling theory and identity-threat model of stigma.

7-2-1. Illness-identity work

In their longitudinal study, Estroff et al. (1991) analysed how the patients with severe, persistent mental illness involved in the study had accounted for illness and self, using two concepts: ‘illness-identity work’ and ‘illness-identity talk’⁴³. Illness-identity work refers to ‘the various enduring processes of biographical and autobiographical revision

⁴³ Most of the patients (N=169) had a diagnosis of schizophrenia or related disorder (39%) or affective disorder (36%), followed by personality disorder (19%) and other (7%). These patients were relatively young, with a median age of 28. Although the authors followed the patients over a two-year period, they reported the findings for the one-year period covered by the first three interviews in this study. Follow-up rate at one year was 80%.

instigated by prolonged and severe dysfunction of any kind (p. 336)'. Illness-identity work produces the words, ideas, actions and so forth, which individuals with disabling conditions use to re-construct and come to terms with their lives. Illness-identity talk is a type of illness-identity work and includes elicited accounts of illness and self-labelling discourse. There are two types of illness-identity talk: normalising statements and illness-identity statements. Whilst the former statements focus upon disagreeing with assignation of illness and re-categorising the condition or the person as common or non-pathological, the latter statements include self-representations encompassing symptoms or illness, description of symptoms in an objective way, separate from self, and self-labelling discourse or labelling discourse made by others. More direct illness-identity statements are expressed by the forms 'I have' and/or 'I am'. These forms include, for instance, 'I have schizophrenia' and 'I am bipolar'.

The authors found that the patients had made a distinction between emotional and cognitive problems, with the former signifying normal experience and the latter signifying a sign of mental illness. In other words, emotional problems were often expressed as normalising statements, whereas cognitive problems were usually found in illness-identity statements. However, a small group of patients thought that emotional excess indicated mental illness; balance was an important element for them. The authors also found that the patients' illness-identity statements included an aspect of temporality, which indicates whether they see their conditions as time-limited or chronic. In the authors' interpretation, the idea that as long as the individual takes medication, he/she is no longer sick and will not get sick again, implies that this person regards his/her illness as time-limited.

In the present study, regardless of the duration of their history of psychiatric treatment, it appeared that the participants' illness-identity work had led to at least some form of conclusion, and they had come to terms with this conclusion by the time of the interviews; the participants were probably not in the process of illness-identity work. In this vein, what I heard in the interviews seemed to be part of their autobiographies which had already been revised by themselves and/or others.

In their illness-identity talk, normalising statements were often associated with commonality. Some of them appeared to regard mental illness, and particularly depression, as relatively common, since there are many people who had been diagnosed with it. One of the clear examples of normalising statements can be found in the words of one participant with depression, as we saw in the previous chapter. According to him, 'In

Tokyo, it's [mental illness is] a given—it's not rare'. Here, by 'mental illness' he meant 'things that you frequently hear about like depression and panic disorders'. There was one participant who thought that schizophrenia was not so stigmatised today because it could affect one in every one hundred people, thus suggesting that he thought that schizophrenia was also relatively common. Despite this however, other participants did not share this view. Although Estroff et al. (1991) noted that one of the aims of normalising statements is focussing upon disagreeing with an assignation of illness, it seemed that this did not hold for the participants in the present study. All of the participants accepted that they had been mentally ill and none of them expressed scepticism about their diagnosis. In this vein, the participants employed normalising statements to situate mental illness, and particularly depression, in one of the common illnesses rather than to disagree with assignation of illness or to view their symptoms as non-pathological. This is similar to the findings of an Australian study (Lloyd, Sullivan and Williams, 2005) and an American study (Whitley and Campbell, 2014), which showed that their participants normalised or universalised mental illness to avoid feeling stigmatised. In the present study, normalising statements about depression were seen both in the participants with schizophrenia and in those with depression. It may be possible to conclude that one of the reasons why most of the participants were reluctant to disclose a diagnosis of schizophrenia was related to their thoughts that whilst depression is a common illness, schizophrenia is not.

With respect to illness-identity statements, these were expressed both in subtle ways and direct ways. In terms of subtle expressions, one of the most frequently found illness-identity statements was about the participants' 'non-normality'. Many participants, and particularly those with schizophrenia, wanted to be regarded as 'normal' by others, which implies that they did not think of themselves as 'normal'. Direct illness-identity statements were present in all the interviews. The participants often used the expressions 'I am' and 'I became'. With regard to the expression 'I am', some participants stated 'I am mentally disordered' or 'I am mentally ill'. When referring to a specific diagnosis, they stated 'Watashi wa Tôgô Shitchô Shô desu' or 'Watashi wa Utsu Byô desu', which literally mean 'I am schizophrenia' or 'I am depression', respectively. The participants also used the expressions 'Tôgô Shitchô Shô ni natta' or 'Utsu Byô ni natta', which literally mean 'I became schizophrenia' or 'I became depression', respectively. These expressions used when referring to specific diagnoses are natural ones in the Japanese language. In the Japanese language, people use these expressions both for physical and

mental illnesses. For instance, they say 'I am cancer' or 'I became cancer'. The 'I have' type of expression is rarely used. However, in the Japanese language, there are almost no natural linguistic options to express that one has an illness other than 'I am' and 'I become'. As such, it would be difficult to infer that the linguistic construction represents a closer association between the identity of an ill person and his/her illness for Japanese people.

As Estroff et al. (1991) found, the participants in the present study also thought that balance was a key element in judging their emotional problems. As we saw in the previous chapter, the participants who went to hospital of their own accord regarded themselves as mentally unwell because of the unusualness of their emotional problems. However, unlike the patients in the study by Estroff et al. (1991), most of the participants in the present study did not appear to view cognitive problems as a sign of mental illness, at least until they learnt about the symptoms of mental illness. They did not regard their cognitive changes as symptoms of mental illness at first, and they situated cognitive problems in the sphere of symptoms of mental illness in the process of learning the symptoms.

With regard to temporality in illness-identity statements, and similar to the findings of Estroff et al. (1991), some participants in the present study also noted that as long as they took medication, they did not suffer from severe symptoms. However, in contrast with the interpretation of Estroff et al. (1991), who found that this type of statement implies that the person regards his/her illness as time-limited, it appeared that this notion was related to chronicity in the participants in the present study. For instance, one participant with schizophrenia stated that he seldom felt that he was ill as long as he was on medication. He was careful when it came to *continuing* to take medication in order to avoid suffering a relapse. Some other participants with schizophrenia stated that they had applied for a job whilst disclosing their illness because otherwise they would not be able to go to hospital on a week-day and/or to take medication at work. This suggests that they were aware that their illness was not a temporary thing but would also affect them in the future. It appeared that the participants in the present study, particularly those with schizophrenia, knew that their illness was chronic but could control it as long as they were on medication, and therefore they should adhere to medication; in their view, temporality was associated with the efficacy of medication, not with the nature of illness.

7-2-2. Labelling theory (1)

Self-labelling

Thoits (1985) argues that, based upon observations by Hochschild (1979; 1983), the members of a society know the emotion norms and feeling rules (how they should feel in a variety of circumstances) in their society, and therefore emotional deviance, or socially inappropriate feelings or feeling displays, may be an important factor in the recognition and labelling of mental illness. According to the theory of Thoits (1985), people are likely to label themselves as mentally unwell and seek professional help when they experience non-normative feelings which are persistent or recurrent and when they lack social support. People cannot ignore these feelings if they are prolonged or frequent. If they notice that they frequently fail to live up to emotional expectations, it is likely for them to attribute their feelings to emotional deviance or disturbance. Others can help them think that it is not unusual to have those feelings by confirming that said feelings have understandable origins in objective conditions. Thoits (1985) calls this social support and argues that those who lack social support are more likely to label themselves as mentally unwell when they frequently experience or continue to experience non-normative feelings than those with it. However, she also notes that others can label people experiencing non-normative feelings as mentally unwell.

Thoits' theory (1985) seems to be applicable to the experiences of the participants in the present study who went to hospital of their own free will. They thought that they might be suffering from mental illness mainly because of the unusual emotions which lasted for some time. They knew the emotion norms and feeling rules in Japanese society, and regarded the feelings they experienced as non-normative. However, it appeared that their personal norms also played an important role in recognising themselves as mentally unwell; they thought that the changes in their emotional state might come from mental health problems because they had never experienced such feelings (or such intense feelings) before. Although social support is one of the essential elements in the theory of Thoits (1985), it was unclear as to whether other people helped the participants view their emotional changes as understandable, since most of them did not talk about the changes to others. They tried to figure out their changes by themselves, by, for instance, searching for information regarding depression on the Internet and using their knowledge about the illness. Although there was one participant who talked about the changes to her sister, who had already been diagnosed with schizophrenia, her sister helped her to recognise the changes as a sign of schizophrenia, rather than helping her

think that the changes were understandable.

7-2-3. Labelling theory (2)

Labelling by others

In his theory about mental illness, Scheff (1965) focusses upon chronic mental illness resulting from 'particular acts which have been publicly and officially labelled as norm violations' (p. 33). In contrast with Thoits' theory (1985), the theory of Scheff (1965) focusses upon labelling by others. He states that his theory is that 'the symptoms of mental illness can be considered to be violations of residual social norms, and that the careers of residual deviants can most effectively be considered as dependent on the societal reaction and the processes of role-playing, when role-playing is viewed as part of a societal rather than an exclusively individual system' (p. 169). Societal reaction to residual rule-breaking is either denial or labelling; residual rule-breaking is not interpreted as a sign of mental illness instantly. In labelling someone, cultural stereotypes may play an important role. When an individual's deviance becomes a public issue, both this individual and those around him/her try to deal with the situation using stereotypes of mental illness, which they have learnt in everyday life since childhood, as a guide. When other people react to the deviance of this individual in this way, his/her unstructured rule-breaking tends to crystallise in conformity to these stereotypes.

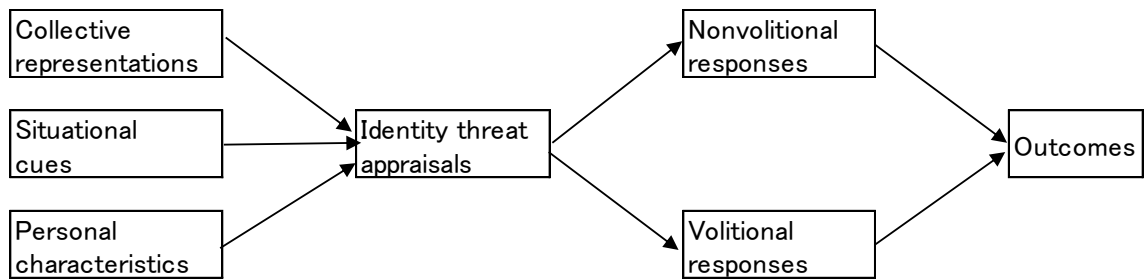
In the present study, eight participants were regarded as mentally unwell by others, mostly their families, and were taken to hospital. These participants believed that (1) their 'odd' behaviour and the reasons for it and (2) their withdrawal from a social life were key factors when it came to other people's recognition that they were mentally unwell. With this said however, there is the possibility that people might have also considered other crucial factors in regarding the participants as mentally unwell. The first key, their 'odd' behaviour, included searching for a wiretap at home and sitting in the same place for almost the whole day at home, doing nothing. Their behaviour may be seen as a violation of residual norms, as people are usually not supposed to do such things at home. Although the participants had a reason (or reasons) for their 'odd' behaviour, other people did not understand their reasoning, which led to these people recognising that they were mentally unwell. One of the reasons why others regarded them as mentally unwell may be related to stereotypes of mental illness, as argued by Scheff (1965). Others might have thought that their reasoning - they had been tapped or they could not move because voices said not to - was similar to or identical to the things mentally ill people

often said. According to the participants' thoughts, for others, their social withdrawal - those who had a job had to resign and those who were students had to withdraw from college because of their symptoms - was also a key factor in terms of them being taken to hospital. Their withdrawal from a social life may be seen as their failure to play the roles they were expected to, which fits Scheff's theory (1965). However, in contrast with his theory, the participants did not appear to have behaved in ways that conformed to the stereotypes of mental illness, even after they started to receive psychiatric treatment. They accepted that they had been suffering from mental illness by the time of the interviews. Other people's views of them and stereotypes of mental illness might have affected their acceptance of being ill, and yet the participants themselves also worked on understanding their illness and reconstructed themselves through their illness-identity work, as shown above. They did not simply accept and stick with the label of mental illness; they denied illness, learnt about it and often concealed it once they accepted their being ill. In this vein, these participants' approach to dealing with the label of mental illness fits with the reactions to the label shown in the modified labelling approach put forth by Link et al. (1989). This approach explains that people with the label of mental illness react to it by concealing it, withdrawing from social interactions and/or educating others.

7-2-4. Identity-threat model of stigma

Major and O'Brien (2005) proposed a theory within an identity threat model of stigma, focussing upon how stigma affects the thoughts, feelings, behaviour and health of the stigmatised. Their theoretical model posits that the collective representations of one's stigma status, situational cues and personal characteristics such as beliefs and motives combine to affect appraisals of the significance of the situation for well-being. Identity threat results when an individual appraises that the demands imposed by a stigma-relevant stressor are potentially harmful to his/her social identity, and that they exceed his/her resources to cope with those demands. Identity threat leads to involuntary responses such as anxiety, while it gives rise to voluntary responses, namely coping strategies. These involuntary and voluntary responses have implications for outcomes such as self-esteem and health (Figure 7).

Figure 7. An identity-threat model of stigma (Major and O'Brien, 2005)



Collective representations, situational cues and personal characteristics

The present study found much to corroborate the theoretical elements suggested by Major and O'Brien (2005). First, both the magazine readers and interview participants were aware of the negatively distorted images of mental illness in Japanese society and that there were people who were prejudiced against it. In other words, they understood that, as persons with mental illness, they were collectively represented in a negative way. Second, most of the readers and interview participants chose to whom they disclosed their illness. This suggests that they were aware of situational cues - who, what, where is safe to disclose their illness. Third, the interview participants' decisions on disclosure often depended on their personal characteristics including motives of how they wanted to be regarded and treated by others and how they wanted to be.

However, situational cues and personal characteristics affected their decisions on disclosure only when they had a choice of concealment or disclosure. As the analysis of the interview data revealed, most of the participants felt that they had no choice regarding disclosure within the family. This signifies that the two theoretical elements have little or no meaning when persons with mental illness are left with no choice as to whether they conceal or disclose their illness or when they are forced to disclose their illness. With this said however, they may well be aware of the negative images of mental illness in society and therefore could may feel reluctant to disclose it.

Identity threat appraisals and responses to them

As suggested by Major and O'Brien (2005), the participants faced a social identity threat when they were directly stigmatised, specifically when they were told prejudicial things or things which were based on ignorance or when they were discriminated against. For instance, in the case of Souta, the participant with schizophrenia who was demoted from

a full-time to part-time worker, his social identity as a full-time worker dealing with a lot of work was threatened. He stated that he had been dissatisfied with working as a part-time worker, which is his involuntary reaction to identity threat. However, he appeared not to have coped with the threat actively. He did not complain about it at the office and worked as a part-time employee, as his superiors had told him to do. Like this participant, whilst the other participants and magazine readers were hurt, sad or angry when experiencing stigma, most of them appeared to have accepted it, rather than to have actively resisted it, although there were a few participants and readers who tried to educate others about mental illness.

The findings of the present study also suggest that not only social identity but also illness identity as a mentally ill person mattered for some people. Some participants had a desire to be regarded and treated as someone with mental illness by specific people such as family members. In other words, when they failed to be regarded and treated as such - when other people regarded them as not ill but as lazy, weak or someone with problems of personality - their illness identity as someone with mental illness was threatened. The findings of the present study suggest, therefore, that the framework put forth by Major and O'Brien (2005) should incorporate illness identity threat to provide a more comprehensive picture.

Outcomes

Involuntary responses of the readers and interview participants in the present study resulted in negative outcomes such as loss of confidence, suicidal thoughts or attempted suicide, which mirrors the framework of Major and O'Brien (2005). Voluntary responses such as education, on the other hand, often led to positive outcomes; by receiving an explanation of mental illness, other people came to understand mental illness and treat the participants as someone who needed care. Major and O'Brien (2005), however, did not include positive outcomes in their framework. The findings of the present study suggest that positive outcomes do exist and therefore their framework should include positive outcomes.

7-3. Implications

7-3-1. Research implications

The major implications for research are two-fold. The first implication is that the personal perspectives of people with mental illness should be more widely acknowledged and

researched in Japan. In Japan there is a dearth of research on personal perspectives of those affected, and this holds not only for research on stigma but also for other areas, including illness experiences. It is unclear whether this is because researchers are not very interested in their personal perspectives or because it is difficult to recruit people with mental illness for research purposes. There is also the possibility that people with mental illness are reluctant to discuss their personal thoughts and experiences for research purposes. The present study showed that stigma against mental illness was endemic in Japan, and this certainly merits further research. This additional research must examine how common the perception, management and experience of stigma are and how these three elements affect people with mental illness in Japan, including the influence on their self-esteem, quality of life, health, and so on. It should be more widely acknowledged that it is essential to understand their thoughts, feelings and experiences so as to, for instance, consider how we can reduce stigma against mental illness. It should also be made clear that discussing personal thoughts, feelings and experiences can lead to a deeper understanding of the lives of people with mental illness or improvements on a practical level such as changes in Laws and welfare services.

Secondly, the present study showed that, whilst there were some affinities between the perception, management and experience of stigma among those with schizophrenia and those with depression, there were also some differences in their experiences. Certain previous studies also found that the perception and experience of stigma could differ between people with mental illness, depending on their diagnosis (Dinos et al., 2004; Bonnington and Rose, 2014). As we saw in Chapter Three, the majority of research on the perception, management or experience of stigma among people with mental illness included those with schizophrenia in their samples, while those with eating disorders, post-traumatic stress disorder or dissociative disorder were under-represented. Future research should examine how different or similar the perception, management and experience of stigma among people with mental illness are, depending on their diagnosis. Ideally, this should include people who have been under-represented in research. Such an examination would lead to, for instance, the identification of specific patterns in the perception, management and experience of stigma in people with a specific diagnosis.

7-3-2. Implications for reducing stigma

In the present study, the experiences of some of the magazine readers and interview

participants showed that education had been one of the solutions for other people's ignorance about mental illness. The analysis of interview data also suggested that it would be necessary to take an approach to reduce families' sense of shame in order for them to accept that their relatives were suffering from mental illness. Furthermore, as the present study found that one of the major concerns of the interview participants was related to obtaining or keeping a job, it will be necessary to change employers' images of and attitudes towards people with mental illness. However, when considering how we can reduce the sense of shame related to mental illness and change employers' images of and attitudes towards people with mental illness, we must first understand the reasons behind them. We need to understand, for instance, why employers are reluctant to hire those affected. Ozawa and Yaeda (2007) showed that Japanese employers with accurate knowledge about mental illness and low levels of prejudice against and fear of people with mental illness had shown higher motivation to employ those with mental illness. This suggests that educating employers about mental illness and reducing their prejudice and fear by providing them with an opportunity to have contact with those affected can be successful in changing employers' images of and attitudes towards people with mental illness. The present study provided only a few possible reasons behind stigma against mental illness, and thus this area should be further researched in Japan.

In an effort to reduce stigma against mental illness, various anti-stigma campaigns and programmes have been conducted over the world, and research has assessed their effects. In the following sub-sections, the findings of prior studies concerning the effects of anti-stigma actions and how it is possible to make use of them in future, particularly in Japan, will be discussed.

7-3-3. Efforts to reduce stigma against mental illness in Japan

To date, some efforts have been made to reduce stigma against mental illness in Japan. For example, the Japanese Society of Psychiatry and Neurology announced the renaming of the old Japanese term for schizophrenia 'Seishin Bunretsu Byô' (mind-split-disease) in 2002.

With regard to the influence of this term change, the old term was quickly replaced with the new term on a clinical level (Satoh, Sugawara and Koiwa, 2004; Takahashi et al., 2008) and most (96%) psychiatrists who principally gave a diagnosis of schizophrenia to their patients used the new term 'Tôgô Shitchô Shô' when doing so in 2003 (Nishimura, 2004). Takahashi et al. (2009) revealed that the old term had been

strongly associated with the word ‘criminal’ in the minds of the participants, whilst there had been no strong association between the new term and criminal among a convenient sample of undergraduate students. Similarly, when surveying their convenient sample of undergraduate and postgraduate students, Koike et al. (2015) found that the participants had more feasible knowledge and fewer negative stereotypes for the new term than the old one. However, they had a significantly greater number of negative stereotypes for the new term than for depression and diabetes mellitus. Furthermore, whereas only 41% of the participants thought that the old and new terms for schizophrenia referred to the same condition, some 87% were aware that the name for dementia had been changed⁴⁴. The findings of these studies on the influence of the term change show that, overall, the new term is frequently used in clinical settings and also gives a less stigmatising impression than the old one. With this said however, it also gives a more negative impression than a different psychiatric or somatic diagnosis, and schizophrenia itself has not received much attention.

Another effort to reduce stigma against mental illness took place in the Laws. Several Laws have been revised in order to prohibit discrimination against people with disabilities or disorders. For instance, although there were quite a few legal regulations which prohibited such people from having a particular licence (including medical or cookery licences), the central government started to review 63 such regulations from 1999 and announced amendments of these regulations in 2002. Six regulations were abolished for all people with any kind of disability or disorder and there were also changes in the prescription for the grounds for disqualification in other regulations; more than 20 prescriptions for the absolute grounds for disqualification (grounds such as ‘all the people with mental disorders cannot apply for this licence’) were changed to the prescriptions for the relative grounds (grounds such as ‘people with mental illness having particular conditions cannot apply for this licence’). One of the examples of these changes, which is related to people with mental illness, pertains to the application for a driving licence; whereas the Road Traffic Law prohibited all people with mental illness from applying for and having a driving licence before 2002, this regulation was deleted and the Law now limits the prohibition to people with mental illness who experience hallucinations (Section 6, 103-1).

⁴⁴ The Ministry of Health, Welfare and Labour discussed the term change for ‘Chihô’ (the old term for dementia, meaning being in his/her dotage) in 2004 and announced the new term ‘Ninchi-syô’ (disorder of cognition), as the old term is stigmatising and misleading (MoHLW, 2004).

Furthermore, a new Law, which aims to eliminate discrimination against people with disabilities or disorders, was promulgated in June 2013 and is to be enforced in April 2016. The central government started to discuss how they can improve the systems for people with disabilities or disorders in 2009, after they signed the United Nation's Convention on the Rights of Persons with Disabilities in 2007. One of the achievements of their activity is the bill of the new Law, which was discussed by specialists in law, welfare or disability studies and representative members of associations for/of people with disabilities or disorders. In response to the bill, in 2014 the Cabinet Office Committee on policies for people with disabilities or disorders sought to gauge the opinions of influential bodies when it came to the future policies derived from the new Law. In order to do this, they surveyed 17 organisations for/of people with disabilities or disorders, 20 organisations of employers and 2 ministries and government agencies. Indeed, this meant that people with disabilities or disorders themselves were involved in creating a new direction for eliminating stigma. The Committee stated in their report that the opinions of these people must be included when reviewing and changing their policies. This new Law may work to reduce discrimination against people with mental illness in the long term, if not instantly.

7-3-4. Anti-stigma programmes in Japan

Although to date the number of anti-stigma programmes has been limited, there are some studies that have examined the effect of educational programmes concerning mental health/illness on people's knowledge and/or attitudes towards mental illness in Japan. In these studies, the participants received information about mental health/illness (for instance, the history of mental health care in Japan or a description of the symptoms of particular mental illnesses) in a lecture. Indeed, the proportion of the participants who gave correct answers in a questionnaire about mental health/illness increased between before and after the lecture (Tanaka, 2005; Yamaguchi and Yoshitake, 2007). During a study by Yamaguchi et al. (2010), people with mental illness gave a talk about their illness experience at schools or universities, which resulted in smaller social distance to people with mental illness among the students who listened to it. Thus, educational programmes and listening to the personal experiences of people with mental illness were effective in improving people's knowledge of mental health/illness and in reducing social distance.

7-3-5. Programmes in other countries: how would it be possible to make use

of their findings?

The present study found that there were quite a few affinities between the perception, management and experience of mental illness stigma between Japanese people and people in other countries. Reviewing the effects of anti-stigma programmes in other countries may help, therefore, when it comes to thinking about how stigma against mental illness can be reduced in Japan.

Dumesnil and Verger (2009) reviewed 43 publications on education campaigns to improve awareness of depression in eight countries (mostly in Europe or Australia). The results showed that the campaigns had improved the knowledge and awareness of mental illness in the targeted population, at least in the short term. They also suggested that the simultaneous application of several strategies, including media campaigns and training of health care professionals, would be more effective in improving knowledge of and attitudes towards mental illness than the distribution of educational material alone. Corrigan et al. (2012) conducted a meta-analysis of 72 articles and reports concerning changing public stigma against mental illness (coming from 14 countries). The results revealed that although contact with people suffering from mental illness and education both had a significant impact on improving attitudes and behavioural intentions towards them, contact had yielded significantly better change among adults. Face-to-face contact, and not by videotape, had the greatest effect. The results of Yamaguchi et al.'s study (2013a), which systematically reviewed the effects of short-term interventions when it came to reducing stigma against mental illness in university or college students, are similar to those of the study by Corrigan et al. (2012). Indeed, both studies found that social contact was the most effective method in terms of changing attitudes and reducing desired social distance. However, Yamaguchi et al. (2013b) found that video contact was also effective in changing attitudes, which contradicts the results of the study by Corrigan et al. (2012). Furthermore, Yamaguchi et al. (2013b) found that education about mental health services had changed students' attitudes towards the use of services in a positive way.

The findings of the studies above show that education is one of the most effective methods when it comes to reducing stigma against mental illness. However, there is also evidence that an increase in knowledge about mental illness does not necessarily lead to improvement in attitudes. Schomerus et al. (2012) systematically reviewed 33 reports on 16 studies concerning mental illness-related beliefs and attitudes in the general population (published before April 2011) (mostly from Europe or the United States). The aim was to

examine the changes in social attitudes towards mental illness over time. A subsample of methodologically homogeneous studies ($n = 6$) was included in a meta-regression analysis⁴⁵. A meta-analysis of the findings on beliefs about causes showed that agreement with ‘inherited/genetic’ cause increased by 1.3% per year in schizophrenia ($p < 0.001$) and by 1.2% in depression ($p = 0.007$) between 1990 and 2006. The estimated increase over the period across all the studies was 21% in schizophrenia and 19% in depression. The proportion of the people who related mental illness to stress remained unchanged at a high level. There was a trend towards increased mental health literacy across five studies. A meta-regression of trends for the two common negative images of mental illness (namely dangerousness and being to blame for the illness), showed no statistically significant changes (number of studies = 3). The findings of other studies regarding these images were inconsistent, with two studies finding a decrease of these images and three an increase of them. With respect to the trend for social acceptance of people with mental illness, a meta-regression of six studies showed a significant decline in accepting persons with schizophrenia as a neighbour and a colleague (the estimated decline for accepting persons with schizophrenia as a neighbour was 16% while for accepting them as a colleague the figure stood at 18%). No significant changes were found in depression. Other studies all observed either no change or inconsistency in time trends or deterioration of social acceptance.

While education can improve attitudes towards mental illness, the results of the study by Schomerus et al. (2012) show that this is not always the case. One of the alternative ways to reduce stigma is to change the images of mental illness in the media; indeed, research has shown that people’s views on mental illness can be affected by the depiction of mental illness in the media (Angermeyer, Dietrich and Matschinger, 2005; Dietrich et al., 2006; Clement et al., 2013). A New Zealand study (Vaughan and Hansen, 2004) and a British study (Thornicroft et al., 2013) revealed that the proportion of stigmatising articles in newspapers had significantly decreased after the introduction of an anti-stigma campaign in the media. The present study showed that newspaper articles pertaining to mental illness were often related to dangerousness, and the readers of the magazines and the interview participants were aware of that. Indeed, it would be ideal if descriptions of mental illness in the media came to include more articles about the

⁴⁵ Studies employing nationally representative samples and examining time trends of social attitudes towards mental illness with a minimum follow-up period of two years were included in the review.

personal stories of those with mental illness and about treatment for, symptoms and causes of mental illness, along with fewer articles associated with dangerousness. If this was achieved, it would affect social attitudes towards mental illness, and people with mental illness may feel less stigmatised. As shown in Chapter Five, reporting about mental illness is similar between Japan and some other countries, and thus media campaigns to reduce stigma may also result in positive changes in Japan. Furthermore, evaluation of anti-stigma campaigns in the media suggests that long-term campaigns are desirable. Research has shown that long-term (several years) anti-stigma campaigns led to better results than short-term (a few weeks) ones. For instance, in a Canadian online media campaign called 'In One Voice', which aimed to raise mental health awareness among young people, although the campaign successfully improved mental health awareness, it was not effective in changing attitudes towards people with mental illness (Yamaguchi et al., 2013a). Therefore, media campaigns lasting for several years, rather than for a short period, will also be effective in Japan. However, a systematic review of mental illness among journalists suggested that journalism's professional culture, which creates and generalises stereotypes of people with mental illness and emphasises danger, may affect the depiction of mental illness in the media (Aoki et al., 2012). In light of this, we need to consider how we could change the culture in order to reduce stigmatising depictions of mental illness. Another alternative method is contact with people suffering from mental illness. As demonstrated by Corrigan et al. (2012), contact yielded significantly better changes than education in the educational programmes. These alternative approaches can affect the negative images of mental illness and negative emotions towards people with it. In addition, they can also change attitudes in a different way to the programmes for improving knowledge about mental illness.

Whilst it can be effective to focus on a specific aspect such as reporting in the media in order to reduce stigma, it is also important to use multiple approaches so as to produce better results. One of the most comprehensive anti-stigma programmes is Time to Change, which was run in England from 2009 to 2011. This programme was funded by the Big Lottery Fund, Comic Relief, Mental Health Media, MIND and Rethink. Time to Change used various approaches to reduce stigma, including holding mass physical exercise events annually during Mental Health Awareness Week in order to facilitate social contact between those with and without mental illness. Indeed, this helped to diffuse factually correct knowledge about mental illness through mass-media advertising and public relations exercises and educated targeted groups such as medical students and

trainee teachers using social contact, both at national and local levels (Henderson and Thornicroft, 2009). An evaluation of Time to Change showed that this programme had positive effects; the proportion of those who experienced discrimination in the previous 12 months significantly decreased between 2008 and 2011 among people with mental illness in England (Corker et al., 2013); moreover, the proportion of negative articles about mental illness significantly decreased in English newspapers over the same period (Thornicroft et al., 2013).

However, what we should be careful about when introducing programmes developed in countries other than Japan is the potential differences in the reasons for stigma against mental illness between countries. Indeed, various anti-stigma programmes have been developed and proved effective in other countries where the reasons for stigma against mental illness were different to those in Japan. However, these may not work in Japan. In light of this, it will be important to understand the factors behind stigma against mental illness in Japan when introducing or developing anti-stigma programmes in the country.

In the present study, stigma was defined as prejudice, ignorance and discrimination according to Thornicroft's definition (2006; Thornicroft et al., 2007; Thornicroft et al., 2009). The present study found this definition useful in understanding the perception, management and experience of stigma among people with mental illness; in addition, the inclusion of ignorance in the definition of stigma made it possible to describe how people with mental illness were treated in a negative way because of other people's ignorance about mental illness. However, as research has shown that an increase in knowledge about mental illness does not necessarily lead to a reduction of stigma, ignorance might not be a crucial factor when considering how to reduce stigma.

7-4. Limitations and significance of the study

The present study has several limitations. Firstly, it did not provide information on how common it is for people with mental illness to perceive, manage and experience stigma in Japan, as it did not employ a quantitative approach. Secondly, as the interview participants had either schizophrenia or depression and the sample did not include those with a different psychiatric diagnosis, the findings of the interview study did not provide a picture of how people with a different psychiatric diagnosis perceive, manage and experience of stigma in Japan. Thirdly, the present study focussed upon limited aspects of stigma (the perception, management and experience of negative stigma) and therefore

it did not give a complete understanding of their perception, management and experience of stigma. Considering that research has shown that experience of illness has both positive and negative sides for people living with mental illness (Dinos et al., 2004; Pitt et al., 2009), it will be possible to obtain a deeper understanding of stigma among people with mental illness by studying their perception, management and experience of stigma as a whole, including the positive aspects. Lastly, the theory developed in the present study may not be applicable to all people with mental illness, as symptom severity, functioning and whether they accept that they are ill vary between individuals.

However, despite these limitations, the present study showed concrete examples of the perception, management and experience of stigma, the relationships between them, and what affects these three elements. The present study also demonstrated the changes in the portrayal of mental illness in newspapers in Japan, relating the findings to the perception, management and experience of stigma among those affected. Both the perception, management and experience of stigma among people with mental illness and the changes in reporting of mental illness over time in Japan have not been studied sufficiently in prior research and therefore the present study provides new findings in that regard. Indeed, this may help us to understand the changes in social attitudes towards mental illness and when thinking about possible ways to reduce stigma against mental illness in Japan. The theoretical consideration of the present study will also contribute to the development of theories about perceiving, managing and experiencing stigma in future research. Furthermore, the findings of the interview study will contribute to a deeper understanding of the perception, management and experience of stigma among those with schizophrenia or depression, particularly those with stable symptoms, although it may be difficult to apply the theory developed in the present study to all people with mental illness.

7-5. Summary

This chapter has discussed the findings of the interview study and magazine article analysis in comparison with the findings of prior studies and has placed the present study's findings within theoretical contexts. There were quite a few affinities between the perception, management and experience of stigma among Japanese people with mental illness and those with mental illness in other countries. However, cultural considerations suggested that there might have been unique reasons behind the perception, management and experience of stigma among Japanese people. Many of the findings of the present

study corroborated the theoretical frameworks developed in previous research, while some of the findings suggested that certain factors, such as illness identity, should have been incorporated into the frameworks in order to provide a more comprehensive picture.

This chapter has also discussed the implications, limitations and significance of the study. Anti-stigma programmes conducted in other countries may work in Japan as well, as the present study found quite a few affinities between the perception, management and experience of stigma among Japanese people with mental illness and those in other countries. However, it will be important to examine the factors behind stigma against mental illness in Japan, when thinking of how to reduce it in the country. With regard to the concept of stigma, the present study found it useful to include ignorance in the definition of stigma to understand how people with mental illness are treated in a negative way because of others' ignorance about mental illness. Despite this however, ignorance about mental illness might not be a crucial factor when trying to reduce stigma, as research has shown that an increase in knowledge does not necessarily lead to favourable attitudes towards those affected.

While the present study has several limitations, such as a focus on limited aspects of stigma and sample bias, it does provide detailed findings about the perception, management and experience of stigma in people with mental illness in Japan and their relationships. The present study also showed the changes in reporting of mental illness in newspaper coverage in Japan, relating them to the perception, management and experience of stigma in those affected. Further, the findings of the present study will contribute to the development of theories about stigma in future research. It will also facilitate an understanding of how people with stable symptoms and who are well-functioning perceive, manage and experience mental illness stigma.

The next chapter presents the conclusion of the present study.

CONCLUSION

In the Preface I defined my objectives as follows: (1) to clarify the time trends in social attitudes towards mental illness in Japan and (2) to clarify how people with mental illness perceive, manage and experience negative stigma in Japan, with a sub-focus on the changes over time. The present study employed document analysis of four newspapers in order to achieve the first aim, and document analysis of three magazines and qualitative interviews to achieve the second aim.

In Chapter Five, I showed that whilst reporting related to dangerousness of mental illness had occupied a high proportion throughout the sample period (1987-2014), the proportion decreased significantly during the period. This was particularly true for depression, whilst the reporting of schizophrenia largely remained related to dangerousness over time. Newspaper coverage, particularly of depression, was found to be changing when it came to the reporting of mental illness in relation to stress and the reporting of personal stories of persons with the illness over the sample period. Most of the findings of the present study agree with those of prior studies conducted in other countries, thus suggesting some affinities between the portrayal of mental illness in Japanese newspapers and those in other countries. With this said however, it is unknown as to whether the reporting trend of articles with a ‘stress caused by work’ theme - most of these articles featured depression - is a unique characteristic of Japanese newspapers.

The findings of magazine article analysis in Chapter Six showed that the readers had perceived negative and distorted images of mental illness in society and had often concealed their illness. Concealment of illness led to a psychological or physical burden in many cases. Only a few readers reported that they had dealt with stigma by educating others on mental illness. There were also quite a few articles reporting experience of stigma, including rejection by friends, demotion or dismissal in the workplace, facing other people’s lack of understanding of mental illness, being treated as ‘mad’ or inferior to others, and so on. With respect to time trends, there were few qualitative changes in the perception and experience of stigma over time, although there were some changes in management since 2007, with the Law revision in 2006. Until 2006, the Law on Employment Promotion of People with Disabilities included only people with a physical or an intellectual disability. However, this Law was revised in 2006, which led to the inclusion of people with mental illness. Following this legal change, some people reported that they had chosen to apply for a job for people with disabilities or disorders. In this

way, they tried to avoid being stigmatised in a job interview and in the workplace.

In Chapter Six, I showed how people with mental illness had perceived, managed and experienced stigma in detail, through an analysis of interview data. The participants' self-perception had changed because of psychiatric diagnosis and symptoms of mental illness, and they had perceived, managed and experienced stigma during the process of living with the self that has changed. Like the readers of the magazines, the participants were aware of the negative images of mental illness in society and most of the participants managed information about their diagnosis by choosing selective disclosure. Although there were a few participants who coped with stigma by educating others, they were in the minority. When the participants feared that they would lose something important to them such as their job or friends, and wanted to be regarded and treated as 'normal', they concealed their illness, although some of them felt a burden of concealment. Most of the participants seemed to be concerned about how others would view them if they knew that they were mentally ill. When disclosing their illness, they chose the people to whom they disclosed their illness; these were, in most cases, people who were close to them. When they disclosed it to people who were not close to them, there were specific reasons for it, including the need to take medication at work. For the majority of the participants with schizophrenia, their diagnosis mattered when disclosing their illness, whereas the participants with depression reported that their diagnosis of mental illness in general, rather than diagnosis of depression, mattered when disclosing it. The difference seemed to be related to the portrayal of schizophrenia or depression in the newspapers. Whereas the depiction of schizophrenia remained related to dangerousness over time, that of depression had been changing, with newspapers placing more emphasis on stress and the personal stories of persons with the illness, as we saw in Chapter Five.

The participants' concealment or disclosure of their illness led to a range of reactions from others, and those who disclosed their illness to people who were close to them generally received positive reactions. However, the majority of the participants experienced stigma as a result of disclosure. Of these participants, some were regarded not as ill but as lazy, whilst other participants were regarded as different from others and were rejected or discriminated against. The participants with depression in particular experienced the first type of stigma, whilst those with schizophrenia often experienced the second type of stigma. Although there were a few participants who never

experienced stigma, all the participants, including those with no experience of stigma, anticipated stigma.

As we saw in Chapter One, mental health care is hospital-centred in Japan and one of its major characteristics is long hospitalisation, although the pattern of psychiatric provision has been gradually shifting towards early discharge, with legal and policy changes. There is a clear difference between Japanese psychiatric provision and that of some Western countries where the trend of a decrease in psychiatric beds had started by the 1970s. Furthermore, research has found that the Japanese respondents showed higher levels of stigma or greater hope for social distance to people with mental illness than respondents in other countries, including Australia, Indonesia, Taiwan and the US. It may be surprising, therefore, that the present study found quite a few affinities between the perception, management and experience of stigma among Japanese people with mental illness and those among people in some Western countries. They shared, for example, experience of rejection by friends, being verbally abused, dismissal or demotion at work, and facing other people's lack of understanding of mental illness. There were, of course, also differences between Japanese people's perception, management and experience of stigma and those of people in other countries. For instance, while Indian people with depression were extremely worried about the impact of their illness on their own or their relative's marriage arrangements (Weiss et al., 2001), Japanese people with mental illness were mostly concerned about work or being regarded as 'not normal' by others. Furthermore, whilst some American people with mental illness reported being rejected by their families, there were no magazine readers and interview participants in the present study who reported this.

One of the reasons for the differences between Japanese people's perception, management and experience of stigma and those of people in other countries may be related to culture or society. Indeed, using cultural and social factors in Japan, one may be able to explain, for instance, why there were no Japanese readers and interview participants who reported rejection by their families. Of particular note here is the *ie* system, and families' awareness of self-care and the expectations of the social role of self-care in families (see Chapter Seven). However, there is the possibility that cultural and social factors are behind even the identical or similar perception, management and experience of stigma, and these factors can vary between countries and areas. For example, research has shown that concealment is one of the most common forms of stigma management in people with mental illness across various countries, and yet the reasons

for concealment can vary between different cultures and societies. In a culture where it is widely believed that mental illness is hereditary, people with mental illness may tend to conceal their illness because of fear that their families will also be stigmatised. Conversely, in a society where people are required to be strong, people with mental illness may tend to conceal their illness because they do not want to appear weak-willed or weak against stress.

In the present study, most of the interview participants were concerned about how others would view them and they wanted to avoid being regarded as ‘not normal’. Indeed, fear and hope were common reasons for the concealment of their illness, and it seemed that the fear and hope were influenced by a cultural factor. As I showed in the previous chapter, referring to an argument about ‘*seken*’, or others in general, other people’s views are norms in everyday life in Japan. People who are living in this culture are required to behave according to other people’s norms, and are required to be ‘normal’ in accordance with other people’s norms. It is, therefore, difficult not to care what others would think of them and it is important to be ‘normal’ in other people’s views. Although the hope of being regarded as ‘normal’ is seen in the participants from the studies conducted in other countries as well (UK; Forrester-Jones and Barnes, 2008; US; Jenkins and Carpenter-Song, 2009), it would be unlikely that this hope stems from the same place as it does for Japanese people. As such, there may be different cultural or social factors behind the hope, or they had hope because of practical reasons (for example, fear of loss of their job) rather than cultural or social reasons.

Furthermore, concrete examples of experienced stigma between the magazine readers and interview participants in the present study and those in other countries were the same or similar in many cases. Despite this however, the reasons why they were stigmatised can also vary between countries and areas. The present study was concerned with the stigmatised, not the stigmatiser, and did not provide detailed explanations about why people stigmatised those with mental illness. Possible reasons for this may include fear, shame, indifference, and a variety of other reasons. It seems important to explore the reasons why people stigmatise those with mental illness and to take action to reduce this in order to consider possible ways of reducing stigma in Japan. Indeed, this is because the background of stigma against mental illness can be different between countries and areas. For this reason, one should be careful about introducing anti-stigma programmes developed in countries other than Japan, for they may not work in Japan if these programmes premise the background of stigma against mental illness which is

different to the reasons why Japanese people stigmatise those with mental illness. Of course, it also is important to examine how people with mental illness are stigmatised and in which areas they are stigmatised when thinking of how we can reduce stigma. Practical approaches such as legal changes to prohibit discrimination against those affected may be effective in reducing stigma. However, it will be difficult to see significant changes in stigma against mental illness unless we try to work on the reasons why people stigmatise those affected. In Japan, little is known about the background of stigma against mental illness. This is the area which should be examined in detail in future research in order to consider possible ways to reduce stigma against mental illness in Japan.

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APPENDIX 1. INFORMATION SHEET FOR PARTICIPANTS

REC Reference Number: SSSL/13/14-6

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

A study on the perception, management and experience of stigma among people who have had a psychiatric diagnosis in Japan

I would like to invite you to participate in this postgraduate research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

- Aims of the research and possible benefits

In this study, I would like to clarify how people who have had a psychiatric diagnosis have felt, managed and experienced ignorance, prejudice and discrimination. By clarifying these, it will be possible to suggest what should be improved and how it should be improved for better community-living of people who have had a psychiatric diagnosis.

- The sponsor of this study

This project is funded by Japan Student Services Organisation, the Ministry of Education and Science.

- Possible participants

This study is recruiting people who have had a psychiatric diagnosis. People with acute symptoms, cognitive impairment and/or substance abuse and those who have any problem with the participation are excluded.

- Procedures of the study

You will receive a set of an Information Sheet, two Consent Forms, two Use, Retention and Re-use Forms and a questionnaire. The questionnaire aims to ask basic information about you (e.g. age, gender and a psychiatric diagnosis you have had).

In the questionnaire, you will also be asked to answer a preferable way of contact from me (e-mail or telephone) and I will contact you to arrange a date and time of an interview. The interviews will be conducted face-to-face or by telephone, depending upon your preference and will take between 30 and 50 minutes. In the interview, I will ask your thoughts about people's knowledge about and attitudes against mental disorder, whether the relationships between you and others have changed after you told about your diagnosis and how you felt when you were treated differently to others in a negative way because of your diagnosis, if you have actually been treated in that way.

Interviews will be recorded, subject to your permission. Recordings of interviews will be deleted upon transcription. If you do not agree to record your interview, I will take detailed notes with your permission. Transcribed data and the notes will be stored on USB keys and personally identifiable data will be encrypted. USB keys will be kept in a locked cupboard in a safe location.

In compensation for time and inconvenience, you will receive a voucher of ¥1,000. If you have a face-to-face interview, you will also receive travelling expenses.

If you do decide to take part you will be asked to sign two Consent Forms and two Use, Retention and Re-use Forms and to return ONE Consent Form and ONE Use, Retention and Re-use Form with a completed questionnaire. Please keep this Information Sheet and another signed Consent Form and Use, Retention and Re-use Form for your reference. If you do not return a signed consent form, this implies that you do not agree to the participation and I will not contact you for arrangement of an interview.

- Possible risks

There is a possibility that you will experience psychological stress and/or harm by remembering unpleasant memories (e.g. memories when you were discriminated against).

- Possible benefits

If you want a summary or a copy of the doctoral dissertation, you will receive it by e-mail.

- Arrangements for ensuring anonymity and confidentiality.

You will be able to use a fictitious name throughout the participation if you want to; you can use such a name in the questionnaire, in an interview and when contacting me. I will give a pseudonym to each participant once an interview has been completed and use the pseudonyms throughout the research (until my doctoral dissertation has been accepted by the College). If you used your own fictitious name in the questionnaire, in an interview and when contacting me, I will handle with your data using a different pseudonym to your original one so that you cannot identify yourself when findings were published.

Returned questionnaires (these include information on your mental health such as your psychiatric diagnosis), your telephone number or e-mail address, signed Use, Retention and Re-use Forms, notes and transcribed data of the interviews will be held until my doctoral dissertation has been accepted by the College and only I will have access to these data and information. Signed Consent Forms will be kept for seven years following the acceptance of the dissertation, as these forms include the records of payment. I will use your telephone number or e-mail address only for contacting you about the study or sending you a copy or summary of the dissertation, and will not use them for other purposes.

You may withdraw any data/information you have already provided up until the 5th of June 2015.

Whilst it is generally the case that information resulting from research remains

confidential between you and me, there are limits to confidentiality and situations where confidentiality will need to be broken. These situations include disclosures of illegal activity, risk of harm to others/self or a public threat as a result of terrorism or infectious disease. If, for example, you disclose to me that you have been doing (or will do) harmful activity (e.g. self-harming behaviour or harmful behaviour to others), I will need to inform your organisational director, your doctor or counsellor of it. In such a case, however, I still seek your consent to disclose the information and consider any reasons given for refusal.

- Anticipated plans for dissemination/publication

I intend to disseminate the research findings through submitting a doctoral dissertation, publishing articles in peer reviewed journals and reporting them at a conference.

- Participation in the study is voluntary and it is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw from the study at any time and without giving a reason.

If you have any questions or require more information about this study, please contact me using the following contact details:

Namino Kunitoh
(E-mail address provided)
(Postal address in Japan provided)

If this study has harmed you in any way, you can contact King's College London using the details below for further advice and information. If you do not mind contacting them in English, I would like you to do so by yourself. If you wish to contact them in Japanese, please send your enquiry to me and I will translate it into English and send my supervisors the translated enquiry.

First supervisor: Professor Nikolas Rose
(Postal address in England provided)

Second supervisor: Professor Ilina Singh
(Postal address in England provided)

APPENDIX 2. CONSENT FORM FOR PARTICIPANTS

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: A study on the perception, management and experience of stigma among people who have had a psychiatric diagnosis in Japan

King's College Research Ethics Committee Ref: SSHL/13/14-6

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researcher involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up until the 5th of June 2015.

**Please tick
or initial**

☐

- I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the UK Data Protection Act 1998.

☐

- I consent to my interview being recorded.

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

- I have received a ¥1,000 voucher (and travelling expenses of ¥_____) for the participation in the study (please fill in the amount of travelling expenses where applicable).

☐

- The information you have submitted will be published as a dissertation; please indicate whether you would like to receive a copy or its summary. If you ticked yes, please also indicate whether you want a copy or summary and fill in your e-mail address to receive it.

I would like to receive a copy / summary (please circle).
E-mail address_____

Yes	No

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

APPENDIX 3. USE, RETENTION AND REUSE FORM

STUDY TITLE

A study on the perception, management and experience of stigma among people who have had a psychiatric diagnosis in Japan

RESEARCHER RESPONSIBLE FOR THE PROJECT

Namino Kunitoh

RESEARCH ETHICS COMMITTEE REFERENCE NUMBER

SSHL/13/14-6

NAME OF PARTICIPANT

.....
.....

1. IDENTIFICATION

I agree to being identified and personally associated with my contribution in this study and in any subsequent publication and use.

Yes ☐

I do not agree to being identified and personally associated with my contribution in this study and in any subsequent publication and use. My name must be removed and my comments made unattributable.

Yes ☐

2. ARCHIVING AND SUBSEQUENT USE

I agree to my

Written contribution ☐

Audio recording ☐

Video recording ☐

Transcript ☐

None ☐

being archived in a public repository for use by other researchers.

3. COPYRIGHT

In order for us to make full use of your contribution and to copy, reformat and reuse it, it is necessary that you assign your copyright to King's College London, and the researcher responsible for this project.

I hereby assign the copyright in my contribution to King's College London, and the researcher responsible for this project

Signed: _____

Date: _____

Signed for the College: _____

Date: _____

4. SPECIAL CONDITIONS

Should access to your contribution be restricted for any period of time? If so explain why.

Please note that King's College London is a public body and is subject to the Freedom of Information Act 2000. This means that the College has a general legal duty to make its information public and this can include research data. Personal and confidential material is excluded though and need not usually be disclosed.

APPENDIX 4. QUESTIONNAIRE

A study on the perception, management and experience of stigma among people who have had a psychiatric diagnosis in Japan

Instruction: Please tick the appropriate box or complete the answer. Unless stated otherwise, please answer the questions in order.

1. What is your age?

2. What is your sex?

☐Male

☐Female

3. Are you currently...?

☐Working as an employee

☐Self-employed or freelance

☐Working paid or unpaid for your own or your family's business

☐Out of work and looking for work

☐Out of work but not currently looking for work

☐Looking after home or family

☐A student

☐Retired

☐Long-term sick or disabled

☐Other (please specify _____)

4. In this study, participants are expected to have had a psychiatric diagnosis.

When did you receive a psychiatric diagnosis for the first time?

In _____(month, year)

☐Do not remember

5. What is your diagnosis? If you have several diagnoses, please specify all of them.

☐I do not know my diagnosis.

6. Have you received psychiatric treatment?

☐Yes, I am currently receiving it. →please go to question 7

☐Yes, I have received it before but not at the moment. →please go to question 7

☐No →please go to question 10

7. How long have you been receiving (or did you receive) treatment in total?

_____ year(s) and _____ month(s)

8. What sort of treatment have you been receiving (or did you receive)? Please tick all the appropriate boxes.

☐Medication

- ☐Psychotherapy (counselling)
- ☐Occupational therapy
- ☐Treatment in psychiatric emergency department
- ☐Psychiatric care from a visiting nurse
- ☐Self-help group
- ☐Other (please specify_____)

9. Have you been hospitalised in psychiatric hospital or in psychiatric department?

☐Yes→How long were you in hospital or in the department in total?

_____ year(s) and _____month(s)

☐No

10. Please give your telephone number or e-mail address. You should only give your contact information if you want to. If you give me your telephone number or e-mail address, I will contact you to arrange a date and time of an interview.

Thank you for taking time to complete this questionnaire.

Please return your completed questionnaire with a signed Consent Form and Use, Retention and Re-use Form in the envelope provided to:

Namino Kunitoh

(Japanese postal address provided)

APPENDIX 5. SUPPORT INFORMATION

If you feel stressed, anxious and/or painful by taking part in the study and you need help, following information may be helpful.

- ✧ Tokyo Lifeline (24-hour telephone services)
*** (Japanese telephone number provided)
- ✧ Osaka Suicide Prevention Lifeline (24-hour telephone service)
*** (Japanese telephone number provided)

These services are free and you can use them anonymously.

Most of prefectures run a telephone service in which you can receive advice about your mental health issues and information on psychiatric services available at nights, weekends and on bank holidays. You can search the telephone numbers at the website of the Ministry of Health, Labour and Welfare:
<http://www.mhlw.go.jp/kokoro/support/ercenter.html>.